STRENGTHENING MEDICARE FOR SENIORS: UNDERSTANDING THE CHALLENGES OF TRADITIONAL MEDICARE'S BENEFIT DESIGN

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

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STRENGTHENING MEDICARE FOR SENIORS: UNDERSTANDING THE CHALLENGES OF TRADITIONAL MEDICARE'S BENEFIT DESIGN

THURSDAY, APRIL 11, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:01 a.m., in room 2322 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Burgess, Blackburn, Gingrey, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Pallone, Dingell, Matheson, Green, Christensen, Sarbanes, and Waxman (ex officio).

Staff present: Matt Bravo, Professional Staff Member; Steve Ferrara, Health Fellow; Julie Goon, Health Policy Advisor; Brad Gantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; John O'Shea, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Heidi Stirrup, Health Policy Coordinator; Phil Barnett, Democratic Staff Director; Alli Corr, Democratic Policy Analyst; Amy Hall, Democratic Senior Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; and Karen Nelson, Democratic Deputy Committee Staff Director for Health.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The time of 10 o'clock having arrived, the subcommittee will come to order. The Chair will recognize himself for an opening statement.

Nearly 50 million seniors rely on the Medicare program for their health care. It is important for us to understand Medicare's current benefit structure and look at ways to modernize it to better serve beneficiaries and protect them from catastrophic costs.

When it was created in 1965, Medicare's benefit design was modeled on private insurance products available at the time. However, while the private insurance market has undergone dramatic

changes in the last half century, Medicare's traditional benefit structure has remained essentially unchanged.

Unlike most private insurance today, which has a single deductible for all medical services, Medicare has separate deductibles for Part A, hospital services, and Part B, physician and outpatient services. While the Part A deductible is rather high—$1,156 in 2012—the Part B deductible is relatively low—$140 in 2012.

Medicare fee-for-service also has a complex and sometimes confusing copayment structure. In addition to the Part A deductible, beneficiaries also pay daily copayments for stays at hospitals and skilled nursing facilities. Depending on how many hospital stays a senior incurs in a year, he or she may owe more than one hospital deductible for a year. In addition to the Part B deductible, beneficiaries also pay a monthly Part B premium, and generally pay 20 percent of most charges for outpatient and physician services.

As Medicare's current benefit structure has no cap on how much out-of-pocket spending a beneficiary can incur, seniors are left open to considerable financial risk and uncertainty. They don't know what they will have to pay when they go in for a procedure or test, and ultimately this uncertainty threatens every senior with the potential of medical bankruptcy. Due to this financial uncertainty, and the lack of comprehensive coverage in fee-for-service, almost 90 percent of beneficiaries purchase or receive supplemental insurance.

Everything about our health care system has changed dramatically since the 1960s as health care has become more and more complex. The models and standards of care, tests, treatments, drugs, and medical breakthroughs that we enjoy today were unknown when Medicare was enacted. In 1965, insurance protected us against hospital costs from conditions that were most likely fatal—heart disease, cancer, and stroke. Today, we use insurance to help manage chronic illnesses and treat diseases, allowing beneficiaries to live for decades and to stay in home and community settings for much longer.

The only part of our health care system that has not evolved since Medicare's inception is Medicare's fee-for-service benefit design itself. We don't give our seniors 1960s medical care—in many cases that would be considered malpractice today—so why do we continue to give them a 1960s insurance product?

We have an obligation to modernize Medicare and standardize its cost-sharing structure. We should have a single deductible for Parts A and B, and we should streamline benefits so that fewer seniors will have to purchase supplemental coverage with money from their own pocket. We should institute a catastrophic cap on out-of-pocket spending to protect seniors from the threat of medical bankruptcy. And with Medicare's unsustainable financial footing—according to its trustees, Medicare will be insolvent by 2024, and as soon as 2017—we need to expand means testing for higher-income beneficiaries, in order to protect the most vulnerable seniors. Let us bring Medicare into the 21st century.

I would like to thank MedPAC Chairman Glenn Hackbarth for agreeing to testify today. In recent years, MedPAC has made many recommendations on how to improve the Medicare program, and we are eager to hear about some of them.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

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However, while the private insurance market has undergone dramatic changes in the last half century, Medicare's traditional benefit structure has remained essentially unchanged.

Unlike most private insurance today, which has a single deductible for all medical services, Medicare has separate deductibles for Part A, hospital services, and Part B, physician and outpatient services.

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As Medicare's current benefit structure has no cap on how much out-of-pocket spending a beneficiary can incur, seniors are left open to considerable financial risk and uncertainty. They don't know what they will have to pay when they go in for a procedure or test, and ultimately this uncertainty threatens every senior with the potential of medical bankruptcy.

Due to this financial uncertainty—and the lack of comprehensive coverage in FFS—almost 90% of beneficiaries purchase or receive supplemental insurance.

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The models and standards of care, tests, treatments, drugs, and medical breakthroughs that we enjoy today were unknown when Medicare was enacted.

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Let's bring Medicare into the 21st century.

I'd like to thank MedPAC's chairman, Glenn Hackbarth, for agreeing to testify today. In recent years, MedPAC has made many recommendations on how to improve the Medicare program, and we are eager to hear about some of them.

Thank you, and I yield the remainder of my time to Rep. _____.

Mr. PITTS. At this point I will recognize the ranking member, Mr. Pallone, for 5 minutes for opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE JR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts, and I am very pleased that you have decided to consider today's topic. Improving and strengthening Medicare for generations to come is a primary goal of mine. In fact, I have dedicated time to ensure seniors have access to affordable health care options and the safety nets that they need to age with dignity and respect.

It is no exaggeration to say that Medicare alone is the most successful health care and anti-poverty program ever, and this is why Medicare should be protected and improved, not left vulnerable to cuts in the years to come.

The Affordable Care Act begins those improvements. It reduces Medicare spending, extends solvency, and brings growth in per-patient costs to record lows. In addition, preventive services are now free of charge to beneficiaries, and we finally have laid the groundwork to reward treatment value over volume.

I believe more can be done, however. The fact is, we are faced with an inevitable reality that our Nation's baby boomers are aging into the program at very high rates, higher rates than we have seen in the past. In fact, 11,000 new seniors become eligible for Medicare every day. So I think we need to explore the option of modernizing the Medicare benefit design. Right now, some beneficiaries already pay too much out of pocket, and for years, my colleagues and I have explored the need for some type of catastrophic cap for seniors, in addition to the fact that Part A and Part B have such divergent cost sharing and deductibles might seem arbitrary and confusing. Why shouldn't Medicare be more seamless and simple?

Given that the average beneficiary makes only $22,500 annually and already spends disproportionately more on health care than a younger person makes this very challenging territory. When you change one side of the ledger, it has an impact on the other side, and any reform must be done without significant cost shifts to seniors.

But what Republicans want to do when they talk about reform is to cut the structural foundation of Medicare, turn the whole thing over to insurance companies, and I can tell you right now that that option is simply a nonstarter. In addition, any proposals must be carefully examined not by how they might save money but how they will benefit beneficiaries, providers and the system as a whole. We can't restructure the program for the sake of generating savings, whether that is in the name of deficit reduction or to help pay for the SGR fix, because that is bad policy. We must modernize the program because it is good for the very real people that it serves and will serve for generations to come. We have to modernize because we recognize that perhaps it is not designed the most efficient or affordable way, and I stand ready to explore those options, but I will not stand by while others lose sight of the importance of Medicare to our Nation's seniors, and I yield back the balance of my time. I don't know if any of my colleagues want time. Then I will yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes for a statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for the recognition.

We have heard it several times this morning already. The 12,000 new beneficiaries added to Medicare every day put pressure on the system and does move it closer towards insolvency. In its current form, Medicare will not be able to meet the promise it has made in a few short years. It is not a surprise. We expect a program designed in 1965 to adapt to the needs and usage pattern of beneficiaries in the 21st century. Medicare's current benefit design needs to be reformed in a way that more adequately reflects the needs and expectations of today's seniors.

The first step in moving toward a higher-performing Medicare program must be the elimination of the flawed Sustainable Growth Rate formula. Last-minute fixes to the formula certainly have burdened this committee, but it has been devastating to beneficiaries and providers, producing an unpredictable payment environment and has risked beneficiaries' access to care. Last week, the majority along with the Ways and Means Committee released the second draft of a proposal to repeal or replace the broken Sustainable Growth Rate formula. The proposal realizes that the key to reforming the system is to enable providers to have flexibility to participate in payment and delivery models that best fit their practice.

There will always be areas where providers choose or need to practice in a fee-for-service model. We must also continue to seek out innovative models that can adapt to changes in clinical guidelines and best practices, but the heart of the issue remains the beneficiary—the patient. As cost pressures increase, we risk the ability to provide access to services for our patients. We must seek reforms that provide patients with greater control of their health care. If we ask a beneficiary to participate in their health care through cost sharing, we are obligated to provide them with transparent cost information so that they can plan for their future needs. It is hard to plan for what 20 percent coinsurance means when you don't know what 20 percent is part of. Enabling patients to be more involved in their care not only allows them greater control of their health care spending but provides greater protections for patients and moves an outdated program into the future.

We have neglected these problems for far too long. We know the structural and fiscal problems in the health care system. The only question now is how long will Americans tolerate Congress staring at these problems without actually fixing them for future generations.

I am very grateful to see Mr. Hackbarth back with us this morning. He has been before our committee several times. MedPAC has recommended a range of different policies over the years to reform Medicare's benefit structure. I certainly look forward to hearing more of these ideas in Mr. Hackbarth's testimony, and I would now like to yield to the gentleman from Georgia, Dr. Gingrey.

Mr. GINGREY. Mr. Chairman, I thank the vice chairman for yielding to me.

As a physician for over 30 years, it was my job to engage with patients and offer them a straight answer no matter the seriousness of the prognosis, and I think at this point it is incredibly important for Congress to do the same thing, to engage seniors on the urgency of Medicare's fiscal situation and work to explain how changes to the current Medicare benefit can decrease personal risk and increase the solvency of the program.

I don't think that anyone here would disagree that the Medicare program of today is in trouble. The hospital trust fund is to set to run out somewhere between 2017 and 2024, whoever you believe, but clearly it is coming. What will happen once this point occurs is anybody's guess. The looming fiscal disaster must certainly be addressed before the fund is exhausted lest we leave beneficiaries with unacceptable costs or lack of access to care, or both.

Mr. Chairman, we must look for ways to improve the Medicare benefit not only for our current seniors but to ensure those benefits are there for future generations. We have a system that was created in the 1960s, as Dr. Burgess was just mentioning, very few adjustments since then. The way we practice medicine today has changed, and it is time for the way we pay for medicine to reflect that, and I thank you, Mr. Chairman, for calling this hearing. I look forward, as I know my colleagues do, to hearing from Mr. Hackbarth. He has been with us, as has been said, a number of times, and his suggestions for restructuring the benefits and incentives to improve Medicare for this country's beneficiaries are welcome. So I thank Dr. Burgess, and I will yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman.

For more than four decades, Medicare has been a critical program for ensuring the health and the financial well being for senior and disabled people. I appreciate the opportunity to talk about ways we can continue to improve the program by broadening the protections for beneficiaries and improving the value of the program for both beneficiaries and taxpayers.

I welcome our witness from MedPAC, Mr. Hackbarth. I appreciate your coming back to our committee. The recognition by MedPAC that we should improve beneficiary benefits by putting a limit on out-of-pocket catastrophic spending, rationalizing deductibles, and making coinsurance and copayments more predictable makes sense, but with any policy, the devil is in the details.

The median income for Medicare beneficiaries is only $22,500 a year. A lot of people think that the elderly are the wealthiest, and there are wealthy elderly but the median income is $22,500. Medicare beneficiaries already pay more out of pocket for health care than individuals under 65. So any proposal to redesign Medicare

that leaves beneficiaries holding the bag is not one that I could endorse.

That is why I am glad to see that a key element of MedPAC's proposal is that it is "beneficiary liability neutral". That is, on average, beneficiary out-of-pocket payment should not increase, and at the same time, we need to keep in mind that there will inevitably be winners and losers within the Medicare population.

There are other elements of MedPAC's redesign option that I believe need more careful scrutiny. MedPAC also recommends adding a charge for supplemental insurance policies, whether provided by employers or purchased by individuals, to offset the financial impact to Medicare of first-dollar coverage. I think there are two important points to be made here, one, that these are not separate proposals. The proposal to reform supplemental coverage is linked and not severable from improving beneficiary benefits. This is important because I would hate to see some of my colleagues who are more concerned with cutting costs than securing benefits try to do one without the other. We also need to carefully assess the impact this could have on the near poor, who do not qualify for Medicare extra help for their out-of-pocket costs and may not have the means to afford any additional costs.

My second point has to do with the unintended consequences that eliminating first-dollar coverage could have on necessary utilization. The problem is that the relationship between cost sharing and service utilization is not the same in low-income and elderly populations, especially sick, elderly populations, as it is in younger, healthier populations. The Medicare population is older, poorer, with 50 percent of beneficiaries at or below 200 percent of the federal poverty level, and sicker, with 40% having three or more chronic conditions, than the general population. As a result, if we make supplemental insurance less affordable or reduce the level of coverage, Medicare beneficiaries are at greater risk of deferring not only unnecessary care, but necessary care, negatively impacting their health.

As we think about opportunities to improve the benefit package in Medicare, we must add protections for beneficiaries and at the same time be careful not to generate both predictable and unintended consequences. We must continue to protect our most vulnerable seniors. Finally, we must make sure that we are not using program redesign as a pretext for reducing spending by shifting costs onto those beneficiaries.

Thank you, Mr. Chairman. I yield back the time.

Mr. PITTS. The Chair thanks the gentleman. That concludes the opening statements of the members.

We have one witness today, and our panel today we have Mr. Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission. Thank you for coming. You will have 5 minutes to summarize your testimony, and your full written testimony will be placed in the record. At this point you are recognized for 5 minutes.

STATEMENT OF GLENN HACKBARTH, J.D., CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Thank you, Chairman Pitts and Ranking Member Pallone and Vice Chairman Burgess and Ranking Member

Waxman. I appreciate the opportunity to talk about MedPAC's recommendations on redesigning the Medicare benefit package.

In our view, the current Medicare benefit package is both inadequate and confusing. It is inadequate in the sense that it lacks catastrophic coverage, that is, a limit on the maximum out-of-pocket costs that can be incurred by a patient. It is confusing with its bifurcated Part A and B structure and a complex system of patient cost sharing, a mixture of copayments and percentage coinsurance. In our view, the status quo, the current benefit package, is not good for Medicare beneficiaries nor for taxpayers.

Because of the inadequate and confusing nature of the Medicare benefit package, many beneficiaries are induced to buy supplemental coverage, often at a very high price. Taxpayers in turn must pay for the increased costs resulting from supplemental coverage that often covers even the first dollar of out-of-pocket expense. In our view, the principal winners from the status quo are the insurance companies that sell supplemental coverage. It is a lose-lose proposition for Medicare beneficiaries and for taxpayers.

With these inadequacies in mind, MedPAC has recommended redesigning the Medicare benefit package consistent with five principles. First, there should be no increase the average Medicare beneficiary liability for out-of-pocket costs. In other words, the benefit package should not be reduced in its actuarial value. We don't believe that Medicare currently is too rich a benefit package. If anything, it is too lean, given the population served. Second, we believe that a redesigned Medicare benefit package should include an out-of-pocket limit, that is catastrophic coverage. Third, we believe that wherever possible, the Medicare benefit package should be simplified, for example, by substituting fixed dollar copays for percentage coinsurance. Our research with beneficiaries shows that fixed dollar copays are much more readily understood and provide some comfort to beneficiaries about what their costs will be for particular services. Fourth, we believe that Congress should give the Secretary of HHS the authority to modify the Medicare benefit package consistent with the principles of value-based insurance design. That means that the Secretary should have the authority to reduce out-of-pocket payments for beneficiaries for services that are established by scientific evidence to be of high value to patients. Conversely, the Secretary should be able to increase copayments for services that evidence shows are of low value to patients. Finally, we recommend that Congress institute a charge on supplemental coverage. The purpose of the charge would be to ensure that beneficiaries who elect to buy supplemental coverage share at least a portion of the additional costs that that private decision results in for the taxpayers and the Medicare program. The premium that a beneficiary pays for supplemental coverage only covers a fraction of the additional costs that the program incurs as a result of supplemental coverage.

Let me conclude with three points that I think bear particular emphasis. One is that patient cost sharing is an imperfect method of controlling costs, albeit a necessary one in the context of a free choice of provider, largely fee-for-service insurance program. We don't believe that patient cost sharing should be the only or even the principal method of trying to control costs. Indeed, most of

MedPAC's work focuses on changing how we pay providers, providing better incentives for high-value care.

The second point I would like to emphasize is that by giving the Secretary the authority to institute value-based insurance design, we can improve the targeting of cost sharing, making it less likely that cost sharing will have an adverse effect on quality and outcomes.

Finally, I would like to emphasize that we would not prohibit Medicare beneficiaries from buying supplemental coverage, even first-dollar coverage, if they so desire. We only think that Medicare beneficiaries should face some of the additional costs that decision imposes on the Medicare program and the taxpayers. I should also emphasize that the supplemental charge we would envision only as part of an overall package. All of these recommendations we see as an integrated package, not isolated recommendations.

With that, Mr. Chairman, I welcome your questions.

[The prepared statement of Mr. Hackbarth follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Reforming Medicare's benefit design

April 11, 2013

Statement of

Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

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Chairman Upton, Ranking Member Waxman, Subcommittee Chairman Pitts, Subcommittee Ranking Member Pallone, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's recommendation to reform Medicare's benefit design.

The Medicare Payment Advisory Commission is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.

Introduction

Over the last several years, the Commission has made a range of recommendations to the Congress regarding traditional fee-for-service (FFS), Medicare Advantage (Part C), and the prescription drug benefit (Part D) designed to improve the coordination and quality of care, to improve the equity of payment, to improve program integrity, and to reduce spending. Most of those efforts have been aimed at providers of care. It was the Commission's judgment that policy changes focused on the provider were the most effective first step to improving the Medicare program. However, there is another actor in the delivery of care—the beneficiary. Here the Commission has also considered policy changes—for example, generating and disseminating quality information, examining shared decision-making protocols, and redesigning the traditional Medicare benefit structure. The Commission has also recommended that Medicare Advantage (MA) and the accountable care organization (ACO) initiative be designed to reward beneficiaries for making cost-conscious choices. In order for Medicare to produce both quality care and lower spending growth, the incentives of providers and beneficiaries need to be aligned to achieve these goals.

The Commission has been considering ways to reform the traditional benefit package with two main objectives: to give beneficiaries better protection against high out-of-pocket (OOP) spending and to create incentives for them to make better decisions about their use of discretionary care. In this testimony, we focus on the Commission's recommended redesign of the FFS benefit package from our June 2012 report and summarize the Commission's views on key design issues related to

restructuring cost sharing under the FFS benefit.

The cost-sharing structure of the traditional FFS benefit has remained basically unchanged since 1965. The current FFS benefit has considerable cost-sharing requirements. For Part A services, it includes a relatively high deductible for inpatient hospital care ($1,184 in 2013) and daily copayments for long stays at hospitals and skilled nursing facilities. Patients with more than one hospital admission in a year can be liable for more than one hospital deductible for the year. For Part B services, the FFS benefit has a relatively low deductible ($147 in 2013) but requires beneficiaries to pay 20 percent of allowable charges for most services, except for home health, clinical laboratory, and certain preventive services. Annual changes in the deductibles and copayments under Part A and Part B are linked to average annual increases in Medicare spending for those services.

Under this design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. As a result, a small percentage of Medicare beneficiaries incur very high levels of cost-sharing liability each year (Table 1). For example, among FFS beneficiaries who were enrolled in Part A and Part B for 12 months in 2009, 6 percent had a cost-sharing liability of $5,000 or more. Without additional coverage, they would be subject to significant financial risk from very high levels of OOP spending.

Table 1. Distribution of Medicare beneficiaries' cost-sharing liability in 2009

Range of cost-sharing liability per beneficiary	Percent of FFS beneficiaries	Average amount of cost sharing liability per beneficiary
$0	6%	$0
$1 to $135 (2009 Part B deductible)	3%	$85
$136 to $499	34%	$289
$500 to $999	19%	$713
$1000 to $1,999	16%	$1,456
$2,000 to $4,999	16%	$3,048
$5,000 to $9,999	4%	$6,869
$10,000 or more	2%	$15,536

Note: FFS (fee-for-service). Amounts reflect cost sharing under FFS Medicare—not what beneficiaries paid out of pocket. Most beneficiaries have secondary insurance that covers some or all of their Medicare cost sharing. Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year and not enrolled in private Medicare plans.

Source: MedPAC analysis based on data from CMS.

But for most Medicare beneficiaries, what they paid out of pocket is much less than their cost-sharing liability. In part due to the lack of comprehensiveness of the FFS benefit design, almost 90 percent of FFS beneficiaries have supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. While this additional coverage addresses beneficiaries' concerns about the uncertainty of OOP spending under the FFS benefit, it also eliminates beneficiary incentives at the point of service and limits Medicare's ability to use cost sharing as a policy tool. As currently structured, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that the service is effective or ineffective. Moreover, most of the costs of increased utilization are borne by the Medicare program, meaning both the taxpayers and other Medicare beneficiaries pay the premiums.

As mentioned, beneficiaries can have supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. For most beneficiaries who purchase Medigap policies, the amount they pay in premiums is often well above the amount they would have incurred in cost sharing in the absence of the supplemental coverage. Yet, beneficiaries continue to buy such

coverage because it has value to them in providing peace of mind. However, even though medigap policies are standardized, it is not easy for beneficiaries to determine the true value of the product they are buying. Medigap policies can have widely varying premiums for the exact same coverage. In learning about policies, most beneficiaries rely on insurance agents, who may not have incentives to help beneficiaries make the optimal choice in deciding whether or not to buy a medigap policy in the first place and, if so, which policy to buy. In addition, outside of the medigap open enrollment period (the 6-month period after turning 65 and enrolling in Part B), switching to a different medigap policy usually would require medical underwriting and higher premiums.

To address the above shortcomings of the current benefit design, the Commission recommended a redesign based on several key principles:

- protect beneficiaries against high OOP spending, thus enhancing the insurance value of the FFS benefit and mitigating the need for beneficiaries to purchase supplemental insurance;
- create clearer incentives for beneficiaries to make better decisions about their use of care;
- hold aggregate beneficiary cost-sharing liability the same as under current law;
- allow for ongoing adjustments and refinements in cost sharing as evidence of the value of services accumulates and evolves; and
- recoup at least some of the additional costs resulting from the higher service use that supplemental insurance imposes on the Medicare program while still allowing risk-averse beneficiaries the choice to buy supplemental coverage if they wish to do so.

In contrast to many recently proposed changes to Medicare benefits that would require beneficiaries to pay more, the Commission's recommendation to hold beneficiary liability neutral reflects our judgment that traditional Medicare's benefit structure is not too rich, especially for the population covered. We believe that the actuarial value of the benefit package should not be reduced while protecting beneficiaries against high OOP spending. At the same time, in recommending an additional charge on supplemental insurance, we maintain that it is reasonable to ask beneficiaries to pay more when their decision to get supplemental coverage imposes additional costs on the program that are not fully reflected in their supplemental

premiums. Those costs are currently paid for by all Medicare beneficiaries through higher Part B premiums and by the taxpayer.

The Commission's June 2012 recommendation to reform benefit design

The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include:

- an out-of-pocket maximum;
- deductible(s) for Part A and Part B services;
- replacing coinsurance with copayments that may vary by type of service and provider;
- secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum;
- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on supplemental insurance.

The Commission's views on the redesign of the Medicare benefit

The recommendation encapsulates the Commission's views on key design issues broadly related to beneficiary cost sharing. The overall structure of cost sharing is defined by: the OOP maximum, above which the beneficiary pays no (or minimal) costs; the deductible, under which the beneficiary pays all costs; and in between, where the beneficiary pays for some portion according to a specified set of rules.

OOP maximum to protect beneficiaries from the financial risk of very high Medicare costs

The Commission maintains that protecting beneficiaries against the economic impact of catastrophic illness is very important. Because the current FFS benefit does not have a limit on the amount of beneficiaries' cost sharing, a small percentage of Medicare beneficiaries incur very high levels of cost sharing each year. Adding an OOP maximum to the FFS benefit would reduce the financial risk for beneficiaries with very high spending and could mitigate the need to purchase supplemental insurance, a significant expense for many beneficiaries.

An OOP maximum is a fundamental feature of an insurance program; it provides financial protection against an unlikely but highly costly event. In general, an OOP maximum is valuable to beneficiaries in two ways. First, those who actually incur catastrophic levels of Medicare costs in a given year would be able to limit their liability at the specified OOP maximum. Therefore, their cost sharing would be lower with the OOP maximum than without it. Moreover, as one considers insurance coverage over a period of several years, a larger percentage of beneficiaries would reach the OOP maximum at some point. For example, the percentage of beneficiaries with annual cost-sharing liability of $5,000 or more at least once over a four-year period is about double the number for a single year—13 percent compared with 6 percent.

Second, even if beneficiaries did not reach the OOP maximum in a given year, they still were subject to less risk of paying for very high OOP spending. Risk-averse beneficiaries want to be protected from uncertainty and variability in medical spending. Therefore, an OOP maximum that makes very high OOP spending less uncertain and variable has real value, regardless of whether the actual OOP spending for a given beneficiary is high enough to benefit from it. Although beneficiaries may vary in the level of protection they desire and may even have difficulty quantifying how much the value of insurance protection is worth to them, the value of an OOP maximum would be the peace of mind some beneficiaries get from having such protection if they need it.

Deductible(s) for Part A and Part B services that may be combined or separate

A deductible is a fixed dollar amount that a beneficiary pays in a given year before Medicare starts paying for covered services. Its use in benefit design is more pragmatic than intrinsic. If the goal of an OOP maximum is to provide insurance protection against very high medical costs and the goal of cost sharing—copayments and coinsurance—is to provide incentives at the point of service, the role of a deductible is mainly to reduce the cost of other aspects of the benefit package, such as premiums, copayments, and coinsurance. (However, compared with copayments and coinsurance, a deductible can have a different effect on incentives at the point of service.) While beneficiaries might consider a deductible to be financially burdensome, their overall cost might be lower due to a lower premium and cost sharing with a deductible than without it.

The current FFS benefit has separate deductibles for Part A and Part B services: $1,184 for Part A services and $147 for Part B services in 2013. This structure of having two distinct parts is mainly historical, reflecting the structure of private insurance as it existed in the 1960s. Since then, the norms in private insurance have changed and a single deductible for all medical services is typical. (Most plans still have a separate deductible for drug benefits.) From a perspective of using cost sharing to create appropriate incentives for beneficiaries, the current structure of deductibles is not ideal: a relatively high deductible for inpatient care, which is usually not discretionary and is less likely to be influenced by cost sharing, coupled with a low deductible for physician and outpatient care, which are more discretionary and more likely to be influenced by cost sharing. A single combined deductible for both types of services might lessen the effects of the current structure on beneficiary incentives somewhat. In addition, it would be easier for beneficiaries to understand and track all Medicare services together, rather than to track them in separate categories.

However, a combined deductible would affect individual beneficiaries' cost sharing differently, depending on their use of services. In general, beneficiaries who use only Part B services—the majority of beneficiaries in a given year—would see an increase in their deductible amount compared with their currently low Part B deductible. In contrast, under a combined deductible (depending on its level), beneficiaries who received inpatient services—roughly 20 percent in a given year—could see a decrease in their deductible amount compared with their currently high Part A deductible. Given these dynamics, beneficiaries' desire for a low combined deductible based on their individual circumstances is certainly understandable. However, their circumstances can change suddenly and unpredictably, and their calculations may turn out very wrong. For example, if individuals who have few health problems get sick unexpectedly, they may be better off under a benefit package with a higher deductible coupled with lower copayments and a lower OOP maximum.

The Commission did not express a definitive position on combined or separate deductibles. However, combining Part A and Part B deductibles presents important challenges for implementation. Under current law, Part A benefits are automatic for individuals who receive benefits from Social Security on the basis of age or disability, whereas Part B enrollment is voluntary. As a result, a small percentage of beneficiaries do not participate in both parts of the

program. About 93 percent of beneficiaries enrolled in Part A also enroll in Part B. For the 7 percent of beneficiaries who participate in Part A or Part B only, issues related to how a combined deductible and OOP maximum would apply need to be resolved.

Copayments, rather than coinsurance, that may vary by type of service and provider

Copayment is a form of cost sharing that specifies a fixed dollar amount paid by the beneficiary at the point of service, whereas coinsurance specifies a fixed percentage of medical expense paid by the beneficiary. The current FFS benefit uses both forms of cost sharing: daily copayments for long stays at hospitals and skilled nursing facilities and 20 percent coinsurance of allowable charges for most Part B services, except for home health, clinical laboratory, and certain preventive services. The Commission prefers the set dollar amounts of copayments because they are more clearly understood by beneficiaries and reduce uncertainty. Especially if the amounts are set to create incentives for beneficiaries to make better decisions about their use of care, copayments are easy to understand, compare, and respond to. Their simplicity makes copayments more effective in influencing people's use of services. Participants in our focus groups echoed these positive qualities of copayments. In contrast, the idea of paying 20 percent of an unknown total bill worried many participants, who considered coinsurance an open-ended liability for which they could not budget in advance. Not having to deal with the hassle of complicated and unpredictable bills was another reason for buying supplemental insurance offering first-dollar coverage.

Compared with the current FFS benefit, any changes in cost sharing—in the form of a deductible or copayments—will bring about changes in beneficiaries' use of services. Ideally, beneficiaries would respond to changes in cost sharing selectively—decreasing the use of nonessential services that are unlikely to improve their health but not changing their use of essential services that are necessary for maintaining good health despite the increase in cost sharing. As discussed in our previous reports, extensive literature about the effects of cost sharing on the use of health care services shows that people generally reduce their use of health care when they have to pay more out of pocket, and vice versa. Their responses tend to vary by type of service—larger responses for discretionary care and smaller responses for urgent care—but not necessarily based on whether the service is appropriate or essential. For example, a Commission-sponsored study

showed that total Medicare spending was 33 percent higher for beneficiaries with medigap than for those with no supplemental coverage, and 17 percent higher for beneficiaries with employer-sponsored coverage.[1] Having secondary insurance was not associated with higher spending for emergency hospitalizations, but it was associated with higher Part B spending that ranged from 30 percent to over 50 percent more. Overall, beneficiaries with private supplemental insurance spent more on elective hospital admissions; preventive care; office-based physician care; medical specialists; and services such as minor procedures, imaging, and endoscopy.

Reduction in the use of both effective and ineffective care raises the question of whether any potential negative effects from reducing essential care could lead to higher rates of hospitalization and ultimately to higher total spending. This issue of "offset effects" may be particularly important if low-income people in poorer health were more likely to forgo needed care, along with nonessential care, as cost sharing increased. (Two recent studies raise concern about such offset effects among Medicare beneficiaries, although the evidence suggests that the size of this offset is unlikely to be large enough to overcome the savings of cost-sharing changes.[2]) The RAND Health Insurance Experiment (HIE) did not show adverse health effects due to reductions in the use of health care for the average person in the study, but those findings are unlikely to hold true for everyone.[3] (The HIE excluded the elderly population from the study.) In fact, although the results were not statistically significant, the HIE found that low-income people with chronic conditions were at greater risk of adverse health outcomes. Because the elderly are more likely to be both low income and have chronic conditions, changes in cost sharing could have an impact on health outcomes among the Medicare population.

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1 Hogan, C. 2009. *Exploring the effects of secondary insurance on Medicare spending for the elderly*. A study conducted by staff from Direct Research, LLC, for MedPAC. Washington, DC: MedPAC.

2 Chandra, A., J. Gruber, and R. McKnight. 2010. Patient cost-sharing and hospitalization offsets in the elderly. *American Economic Review* 100, no. 1 (March 1): 193-213. Trivedi, A. N., H. Moloo, and V. Mor. 2010. Increased ambulatory care copayment and hospitalizations among the elderly. *New England Journal of Medicine* 362, no. 4 (January 28): 320-328.

3 Newhouse, J. P. 1993. *Free for all? Lessons from the RAND Health Insurance Experiment*. Cambridge, MA: Harvard University Press.

The Commission recognizes that cost sharing may be too blunt a tool because beneficiaries respond to changes in cost sharing indiscriminately. Ideally, cost sharing would work in conjunction with other management tools for encouraging efficient and appropriate use of health care. However, in the Medicare FFS environment with open-ended service use and provider participation, cost sharing may be one of the few policy tools available.

Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services

Over the long term, the Medicare program needs to move toward a benefit design that gives individuals incentives to use higher value care and discourage using lower value care. Policymakers have become more aware that not all health care services have the same value—or the same value for everyone—but identifying which services are of higher or lower value for a given individual is difficult.[4] These determinations must be evidence based, and several years ago, the Commission recommended that policymakers establish an independent public–private entity that would produce information to compare the clinical effectiveness of a health service with its alternatives. The Congress created the Patient-Centered Outcomes Research Institute to identify national priorities for and sponsor comparative clinical-effectiveness research.

The Commission maintains that the ultimate implementation of changes to the FFS benefit design must not only specify a set of cost-sharing requirements and define services to which those requirements would apply but also allow for flexibility to alter or eliminate cost sharing based on the value of services. To encourage the use of high-value services and discourage the use of low-value services, the Congress should consider giving the Secretary authority to reduce cost sharing on services if evidence indicates that doing so would reduce Medicare spending or lead to better health outcomes without increasing costs, or to raise cost sharing on low-value services. This authority would be exercised through the usual notice and comment rulemaking process. For example, under current law, there are no cost-sharing requirements for many preventive services, and the Secretary has administrative authority to modify or eliminate coverage of preventive

4 The term "value based" is used in two ways. Value-based purchasing refers to strategies for paying providers, and value-based insurance design refers to cost-sharing options designed to encourage beneficiaries to use high-value health care services or providers and discourage use of low-value services or providers. Testing these approaches would help policymakers decide which of them could steer beneficiaries more effectively toward the use of high-value services or away from low-value services.

services based on evidence. This flexibility to adjust and refine cost sharing is especially important as evidence evolves. This provision does not diminish congressional authority. If the Congress disagreed with the Secretary's proposed actions, it could act to stop the changes.

No change in beneficiaries' aggregate cost-sharing liability

There are many different ways to combine the three design elements discussed earlier. Within the general structure of cost sharing defined by a deductible, a set of copayments by type of service, and an OOP maximum, there are—in theory—many possibilities consisting of different levels of cost-sharing amounts and definitions of services to which they are applied. In practice, however, a set of feasible design combinations would be constrained by the overall cost of those choices.

The Commission considers it important to allow for different possible combinations of design elements and subsequent adjustments and refinements by the Secretary. However, the Commission does not wish to shift the cost of improving the benefit package to provide better protection against high OOP spending to the beneficiary in the aggregate. Therefore, the Commission has recommended holding the average cost-sharing liability of the beneficiary the same as under current law. In effect, this approach allows the Congress to set the overall value of the Secretary's benefit package and the Secretary is then given discretion within that limit.

An additional charge on supplemental insurance to recoup at least some of the added costs imposed on Medicare

For most Medicare beneficiaries, their actual OOP spending is much smaller than their cost-sharing liability under FFS Medicare because they have additional coverage. In fact, the lack of comprehensive coverage in the FFS benefit design leads many beneficiaries to take up supplemental coverage that fills in some or all of Medicare's cost sharing and protects them from catastrophic financial liability.

At the same time, supplemental coverage can lead to more use of services and spending. In general, there are two possible reasons for the higher spending. First, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that a given service is effective or ineffective. Under such minimal exposure to cost sharing, beneficiaries have incentives to receive more care without experiencing additional OOP

costs, and providers have no incentives to manage utilization. Therefore, some portion of the higher spending observed among beneficiaries with supplemental coverage is arguably due to an insurance effect (also called moral hazard). Second, beneficiaries who are sicker and likely to use more services are more likely to buy supplemental coverage. Conversely, beneficiaries who are healthy and do not expect to use many services are more likely to risk potentially high cost sharing without supplemental coverage. It is likely that this selection effect is also partly responsible for the higher spending observed among those with supplemental coverage.

Since the FFS benefit provides indemnity insurance, cost sharing is one of the few means by which the Medicare program can provide incentives affecting beneficiaries' use of medical services. But almost 90 percent of FFS beneficiaries have supplemental coverage that fills in some or all of Medicare's cost sharing, effectively nullifying the program's tool for influencing beneficiary incentives. By effectively eliminating FFS Medicare's price signals at the point of service, supplemental coverage generally masks the financial consequences of beneficiaries' choices about whether to seek care and which types of providers and therapies to use. Therefore, unless supplemental policies were restructured to retain some cost sharing, any changes in cost sharing in the FFS benefit package would have a limited effect on beneficiaries with supplemental coverage.

There are two philosophically different approaches to address the insurance effect of supplemental coverage. One approach is to regulate how supplemental policies can fill in FFS cost-sharing requirements (for example, redefine medigap policies so that they no longer completely fill in FFS cost-sharing requirements). Another approach is to impose an additional charge on supplemental policies. Rather than prohibiting supplemental insurance from filling in all of Medicare's cost sharing, this approach would not change the use of Medicare services among beneficiaries who choose to keep their supplemental coverage. However, it would change the effective price of their coverage. If the regulatory approach can be described as not allowing beneficiaries to add costs to Medicare through supplemental coverage, the additional charge approach can be described as allowing beneficiaries to add costs to Medicare but requiring them to pay for at least some of those additional costs.

In considering policies related to supplemental coverage, the Commission prefers the additional charge approach over the regulatory approach. The additional charge would apply to most sources of supplemental coverage, including medigap and employer-sponsored retiree plans. (However, implementing consistent changes with respect to medigap and employer-sponsored retiree plans would require different legislative changes. The additional charge would not apply to MA plans because they are at risk for benefit designs that increase costs relative to their capitation payments and are able to employ other tools for managing their enrollees' use of services.) The Commission considers it important that risk-averse beneficiaries who wish to buy first-dollar coverage or reduce the uncertainty in their OOP spending through supplemental insurance should be allowed to do so but effectively at a higher price. Regulating supplemental benefits, in contrast, would prevent even those beneficiaries who very much value extra insurance from buying such policies at any price.

Illustrative benefit package

Table 2 presents an illustrative benefit package consistent with the Commission's views on FFS benefit design reform. The package is modeled after the MA-style benefits that include the following copayments: $20 for each primary care physician visit, $40 for each specialist physician visit, $100 for each hospital outpatient visit, $750 for each inpatient hospital admission, and $80 for each skilled nursing facility day. We also included a $150 copayment per episode for home health care. The Commission's recommendation would require a range of copayments for durable medical equipment and Part B drugs. However, for simplicity, we included 20 percent coinsurance for durable medical equipment and Part B drugs. The annual OOP maximum is $5,000. To keep cost sharing relatively reasonable, the package includes a $500 combined deductible. We kept the overall beneficiary cost-sharing liability of this package roughly equal to that of the current FFS benefit. We want to emphasize that this package is for illustration only, to analyze the trade-offs between design elements. It does not represent the Commission's recommended benefit package.

Table 2. Illustrative benefit package

FFS benefit package	Illustrative package keeping beneficiary liability neutral
OOP maximum	$5,000 per year
A & B deductible	$500 per year
Hospital	$750 per admission
Physician	$20 PCP/$40 specialist visit $100 advanced imaging
Part B drugs	20% coinsurance*
Outpatient	$100 per visit
SNF	$80 per day
DME	20% coinsurance*
Hospice	0% coinsurance
Home health	$150 per episode**

Note: FFS (fee-for-service), OOP (out-of-pocket), PCP (primary care physician), SNF (skilled nursing facility), DME (durable medical equipment).
*For simplicity, we modeled 20 percent coinsurance for durable medical equipment and Part B drugs; copayments in these categories would require a range of copayments.
**We modeled the $150 copayment per episode considered by the Commission in 2011 as a 5 percent coinsurance on home health services.

In general, the set of copayments in the illustrative benefit package is within the range of typical copayments we see in MA plans. However, MA plans tend to use medical management to complement their use of cost sharing and to mitigate the potentially negative effects from reducing essential care or increasing less essential care. While copayments can make beneficiaries aware of the price of care at the point of service, thus creating incentives to make better decisions about their use of discretionary care, medical management can mitigate the effects of reducing care indiscriminately.

The following analysis of spending and distributional impacts is based on the above illustrative benefit package combined with a 20 percent additional charge on medigap and employer-sponsored retiree plans. (An additional charge would need to be significantly greater than 20 percent to recoup the entire cost of higher service use imposed on the Medicare program by beneficiaries with supplemental coverage.) The scope of the analysis excludes dual-eligible beneficiaries because we assumed current law where Medicaid would fill in any changes under the alternative benefit package and would keep the cost sharing the same for those beneficiaries.

Spending impacts

We modeled the effects of the above illustrative benefit package using Medicare claims data from 2009. (Our June 2012 report includes a detailed discussion of the assumptions underlying our

analysis.) Table 3 shows the relative change in annual Medicare program spending under the illustrative benefit package, combined with a 20 percent additional charge on supplemental insurance. It presents only a one-year snapshot of relative changes. Most importantly, it does not represent a budgetary score, which would take additional factors into account.

Table 3. Budgetary effects of the illustrative benefit package, 2009

Percent keeping supplemental coverage	Percent change in Medicare program spending in 2009	Revenue offset generated by 20% additional charge	Net percent change in Medicare program spending
All	+1.0%	-1.5%	-0.5%
75%	0.0%	-1.0%	-1.0%
50%	-1.5%	-0.5%	-2.0%
None	-4.0%	0.0%	-4.0%

Note: Numbers are rounded to the nearest 0.5 percent. Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We estimated a one-year snapshot of relative changes in Medicare program spending, compared with the actual spending in 2009, if the illustrative benefit package had been in place. Additional charge on supplemental insurance represents revenue to the program and is shown as a decrease in program spending. These estimates do not represent a budgetary score, which would take additional factors into account.

Source: MedPAC analysis based on data from CMS.

Under the illustrative benefit package, which holds average beneficiary cost-sharing liability roughly equal to current law, program spending would increase by about 1 percent if all beneficiaries kept their current levels of supplemental coverage. Given the OOP maximum—which made the illustrative benefit package more generous compared with current law—the same level of cost-sharing liability would correspond to higher total spending under the illustrative benefit package. As a result, program spending would also be higher. However, the 20 percent charge on supplemental insurance would generate about 1.5 percent in revenue offsets. The net budgetary effect would be about 0.5 percent in savings. In contrast, if all beneficiaries dropped their current supplemental coverage, program spending would decrease by about 4 percent because of reduced utilization, and no revenues would be collected from the additional charge on supplemental insurance, with a net budgetary effect of about 4 percent in savings.

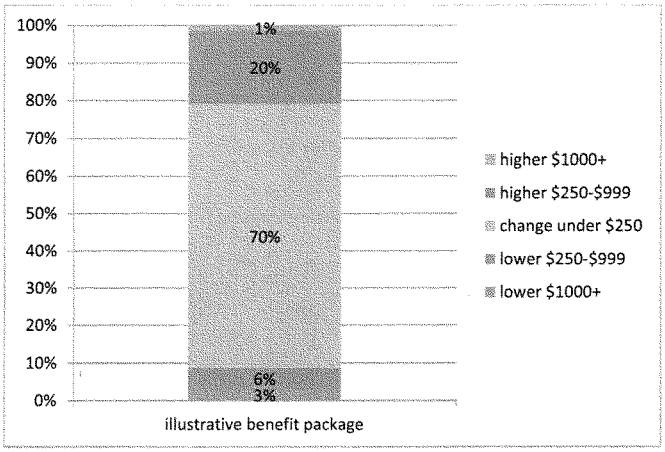
Distributional impacts

Overall, the average beneficiary cost-sharing liability under the illustrative benefit package would be roughly equal to current law by design. However, it would be much less variable because of the

OOP maximum. For example, assuming no change in current supplemental coverage, the standard deviation of cost-sharing liability in 2009 among beneficiaries included in our analysis decreased from $2,370 under current law to $1,250 under the illustrative benefit package, around the mean liability of $1,380.

The effects of the illustrative benefit package (without the 20 percent additional charge) on beneficiaries would vary by their use of services. First, those beneficiaries with cost-sharing liability above the $5,000 OOP maximum and no supplemental coverage would see their OOP spending go down. In Figure 1, this group would be included in the 9 percent of beneficiaries whose OOP spending decreased by $250 or more. (Results in Figure 1 assume no change in supplemental coverage among beneficiaries who currently have supplemental coverage.) By contrast, those beneficiaries with no hospitalization and low use of Part B services would see their cost sharing go up, since the revised benefit design would effectively lower the Part A deductible and raise the Part B deductible compared with current law. In Figure 1, this group would be included in the 21 percent of beneficiaries whose OOP spending increased by $250 or more. In general, beneficiaries with at least one hospital admission would see their cost sharing go down under the illustrative benefit package compared with the current benefit package. For the majority of beneficiaries (70 percent), their OOP spending would not change much because for many of them, their supplemental insurance would dampen the changes in their cost-sharing liability.

Figure 1. Changes in Medicare out-of-pocket spending under the illustrative benefit package, 2009



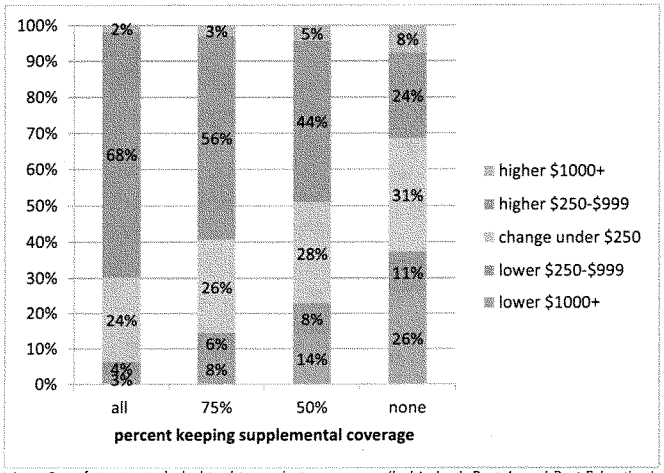
Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We assumed no change in supplemental coverage among beneficiaries who currently have supplemental coverage. Out-of-pocket spending excludes Part B premium.

Source: MedPAC analysis based on data from CMS.

Some beneficiaries who currently have supplemental insurance would drop or reduce their coverage in response to the additional charge and new Medicare benefits. In theory, changes in the FFS benefit and the additional charge on supplemental insurance could alter the individual cost-benefit analysis of having supplemental coverage. First, for some individuals, the benefit of extra protection provided by supplemental insurance would be lower if the FFS benefit were to have an OOP maximum. Without a larger decrease in supplemental premiums to offset the lower value, those beneficiaries would choose to drop supplemental policies. Second, holding the FFS benefit constant, the additional charge on supplemental insurance would increase the effective premiums on those plans and provide an incentive for beneficiaries to switch to medigap policies that required paying more of Medicare's cost sharing or to drop supplemental coverage altogether. If beneficiaries were to drop supplemental insurance, they could choose to stay in traditional FFS or switch to MA.

Figure 2 shows the estimated distributional impact of changes in total OOP costs—the sum of OOP spending and supplemental premiums—under four scenarios: Among beneficiaries who currently have medigap and employer-sponsored retiree insurance, we assumed that all, three-quarters, half, or none of them keep their current supplemental insurance. Compared with Figure 1, the distributional impacts in Figure 2 are noticeably different. For beneficiaries who keep their supplemental coverage, total OOP costs would be higher because of the 20 percent additional charge on supplemental insurance: At 2009 premium levels, the 20 percent additional charge would translate into a $420 increase per year ($35 per month) on medigap plans and a $200 increase per year on employer-sponsored retiree plans. In contrast, for beneficiaries who drop their supplemental coverage, total OOP costs would be the net effect of higher cost sharing paid OOP and savings on their supplemental premiums ($2,100 per year on medigap plans and $500 per year on employer-sponsored retiree plans, assuming a 50 percent employer subsidy rate).

Figure 2. Changes in Medicare out-of-pocket spending and supplemental premium under a 20 percent additional charge on supplemental insurance, 2009



Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We assumed four different levels in take-up rates among beneficiaries who currently have medigap insurance: 100%, 75%, 50%, and 0%. Out-of-pocket spending excludes Part B premium. The change in supplemental premium includes the 20% additional charge on supplemental insurance. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis based on data from CMS.

If all beneficiaries kept their current supplemental coverage, the 20 percent additional charge on supplemental insurance would increase the total OOP cost significantly. Whereas 70 percent of beneficiaries would have little change in OOP costs under the illustrative benefit package in Figure 1, 70 percent of beneficiaries would have an annual increase of $250 or more under the illustrative benefit package in Figure 2 because of the 20 percent additional charge on supplemental insurance. The distribution shifts as fewer beneficiaries keep their current supplemental coverage, since the savings from dropping their medigap or employer-sponsored retiree plans decrease their total OOP costs. If all beneficiaries dropped their current supplemental coverage, 32 percent would experience an increase of $250 or more. Additionally, 31 percent would have little change in their OOP costs 36 percent would see a decrease of $250 or more.

Improving the Medicare benefit for beneficiaries

Distributional impacts discussed earlier highlight that a small percentage of beneficiaries incur very high cost sharing in a given year and thus would benefit from the OOP maximum under the illustrative benefit package. But a larger percentage of beneficiaries would reach the OOP maximum at some point over a longer period of time. Table 4 compares beneficiaries' hospitalization and spending over one year versus four years. For example, in 2009, 19 percent of full-year FFS beneficiaries had at least one hospitalization, whereas 46 percent did from 2006 to 2009. Similarly, 6 percent of full-year FFS beneficiaries had $5,000 or more in cost-sharing liability in 2009, whereas 13 percent had at least one year of $5,000 or more in cost-sharing liability over four years.

Table 4. More beneficiaries would be better off with an out-of-pocket maximum over time

Full-year fee-for-service beneficiaries who had:	2009	2006-2009
1 or more hospitalizations	19%	46%
2 or more hospitalizations	7%	19%
$5,000 or more in annual cost-sharing liability	6%	13%
$10,000 or more in annual cost-sharing liability	2%	4%

Note: Includes beneficiaries who were enrolled in fee-for-service Medicare for four full years, from 2006 to 2009. Excludes those who had any months of private Medicare plan enrollment.

Source: MedPAC analysis based on data from CMS.

The overall spending patterns of Medicare beneficiaries show that in a given year, Medicare spending is highly concentrated, with a small number of beneficiaries accounting for a large proportion of the program's annual expenditures. This pattern is characteristic of insurance programs in general. However, only about half of beneficiaries with high spending one year continue to incur high spending the next year. Although the presence of serious chronic illness can predict high spending, much of very high spending is largely random, due to health costs that are unpredictable. This spending pattern implies that the probability of catastrophic spending over time is higher than the probability in one year would indicate. Even beneficiaries with low spending in a particular year would benefit from the financial protection of insurance as they face greater odds of having a high-spending year over time. Therefore, additional insurance protection that mitigates the risk under Medicare would be valuable to beneficiaries.

One key purpose of insurance is to reduce the financial risk posed by catastrophic medical expenses. Risk-averse individuals want protection from the risk of very high and unpredictable medical expenses. To avoid such risks, they should be willing to pay a premium higher than the average cost of care they might face. The more risk-averse they are, the more willing they are to pay for the insurance. And the more variable potential outcomes are, the more valuable the insurance protection will be. For example, under the illustrative benefit package, the average cost-sharing liability is about the same as under current law, at about $1,380. However, the distribution of cost-sharing liability is much less variable because of the OOP maximum, as

summarized by the standard deviation of $1,250 compared with $2,370 under current law (see Table 5). Although the average cost-sharing liability is about the same, the illustrative benefit package offers much lower financial risk and provides greater insurance protection to beneficiaries.

Table 5. Out-of-pocket maximum reduces the risk of high medical expenses, 2009

	Average cost-sharing liability, 2009	Standard deviation of cost-sharing liability, 2009
Current law	$1,380	$2,370
Illustrative benefit package	$1,380	$1,250

Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We estimated the cost-sharing liability in 2009 if the illustrative benefit package had been in place, compared with the actual cost-sharing liability in 2009.

Source: MedPAC analysis based on data from CMS.

Although most people are risk averse and are willing to pay to reduce risk, an optimal benefit design does not mean no risk at all. The Commission's recommendation on the redesign of the FFS benefit package attempts to balance this fundamental trade-off between two opposing forces—risks and incentives—in the context of an unrestricted FFS system where very few policy tools are available for encouraging efficient and appropriate use of health care.

Mr. PITTS. Thank you, Mr. Hackbarth. The Chair recognizes himself for 5 minutes for questioning.

Mr. Hackbarth, many experts have noted that traditional Medicare is an outdated form of health insurance coverage and needs to be modernized. In 1999, AARP's Public Policy Institute published a paper entitled "The Effects of Merging Part A and B of Medicare." They said, "Medicare's two-part system continues to mirror the structure of private insurance at the time of Medicare's inception in 1965, a structure that often included separate insurance for hospital and physician care." Do you agree with the AARP that Medicare's separate hospital and physician benefits closely resemble the type of insurance available to consumers in the 1960s?

Mr. HACKBARTH. Yes.

Mr. PITTS. Medicare Advantage, a more modern type of coverage signed into law in the late 1990s, is also modeled closely after the types of insurance available to consumers at the time. Do Medicare Advantage plans use separate insurance for hospital and physician care?

Mr. HACKBARTH. No, not to my knowledge, sir.

Mr. PITTS. Medicare drug plans are even more modern, having been passed into law by Congress in 2003. Do Medicare drug plans have catastrophic coverage caps?

Mr. HACKBARTH. Yes.

Mr. PITTS. Is the traditional Medicare benefit the only type of comprehensive coverage in Medicare that does not have a catastrophic coverage cap?

Mr. HACKBARTH. Yes.

Mr. PITTS. And for the record, is it MedPAC's position that Congress should update traditional Medicare fee-for-service to include a catastrophic coverage cap, among other reforms, because these reforms would benefit seniors.

Mr. HACKBARTH. Yes.

Mr. PITTS. Thank you. Nearly 50 years have passed, and Medicare's model has become outdated. Seniors deserve a modern product that meets their needs and helps them control cost. I think it is time for Congress to strengthen and save Medicare, making sure that current beneficiaries get what they need and also that future retirees can count on the program being there for them one day.

Now, AARP's Public Policy Institute paper also states that "A third criticism of two systems of financing for Part A and Part B has hindered management of the original fee-for-service Medicare. Integrating all of Medicare's funding sources into one pool of money would enhance management of health resources and improve accountability for health spending in FFS Medicare." Can you tell us your thoughts on what impact this antiquated two-tiered financing system within traditional Medicare has on CMS's ability to manage health spending appropriately, and do you believe it is possible that the antiquated manner in which traditional Medicare fee-for-service is financed might be contributing to the amount of waste, fraud and abuse lost each year?

Mr. HACKBARTH. So you are asking about the financing, separate financing of A and B with payroll tax used to finance Part B and premiums and general revenues for Part B?

Mr. PITTS. Yes.

Mr. HACKBARTH. We have not specifically looked, Chairman Pitts, at the financing mechanisms and what the implications would be for fraud and abuse. We have focused on the benefit design and payment methods for providers primarily.

Mr. PITTS. Now, you state in your testimony one key purpose of insurance is to reduce the financial risk posed by catastrophic medical expenses. To avoid such risk, individuals should be willing to pay a higher premium than the average cost of care they might face. Can you expand on that idea for us?

Mr. HACKBARTH. Well, probably the single most important feature of any insurance program is a limit someone can incur. Now, the medical expense is that most of it is unpredictable. So any given beneficiary in any given year might pay a premium but not use the insurance, may not use the catastrophic cost yet you pay the premium against the risk that it might be your year to have a very serious illness and incur high bills. That is the nature of insurance. A lot of people pay an amount, don't use the full amount, they pay premiums higher than their actual incurred expenses so that when their day comes and unfortunately they suffer a severe illness, the protection is there for them.

Mr. PITTS. My time is expired. Thank you. The Chair recognizes the ranking member of the subcommittee, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. Hackbarth, I am just following up to some extent on what the chairman just said. While MedPAC included a unified deductible combining the Part A and B deductible into one unified deductible, in your illustrative scenario you did not actually recommend a unified deductible. So why is that? Can you talk about the pros and cons of a unified deductible?

Mr. HACKBARTH. You are correct, Mr. Pallone. We did not specifically recommend a unified deductible. We felt that the precise structure of the cost sharing is a decision that ought to be delegated to the Secretary in keeping with the principles of value-based insurance design. The argument for a combined deductible is that it is simpler and that it is more in keeping with the basic principles of insurance where you want to provide the most protection to patients that have the highest cost. The current structure, as you well know, has a relatively low deductible on Part B and a significantly higher——

Mr. PALLONE. So what is the downside then?

Mr. HACKBARTH. The downside of moving to a combined deductible is the impact on beneficiaries who use only Part B services in any given year. They would have a higher deductible than the current $147 that they have in Part B deductible.

Mr. PALLONE. All right. Let me ask about SGR reform. I appreciate the fact that MedPAC continues to lead and support SGR reform and I share the sentiment of the commissions that it is past time to take action. I also appreciate the recognition that we need to move delivery systems and payment systems reform to more value-based systems that were included in the ACA like the medical homes and accountable care organizations. But with regard to SGR reform, is my understanding correct that MedPAC is not recommending that costs be shifted to beneficiaries?

Mr. HACKBARTH. Well, we have recommended in benefit design, as I said in my opening comment, that the average liability for beneficiaries not be increased.

Mr. PALLONE. OK. So just to clarify further, MedPAC has not recommended that an SGR fix be offset within Medicare. Is that accurate?

Mr. HACKBARTH. We did not recommend that. We believe that is Congress's decision to make. What we have tried to do is offer options for offsetting the cost within Medicare if Congress elects to fully offset SGR within Medicare.

Mr. PALLONE. But you are not recommending that be offset within Medicare?

Mr. HACKBARTH. We have not.

Mr. PALLONE. Now, I am concerned that some people are eyeing this idea of Medicare benefit redesign as a way to simply get budgetary savings by shifting more costs onto the backs of beneficiaries. However, in looking at your redesign recommendations, I notice that you recommend beneficiary liability remains neutral, that overall beneficiary cost-sharing levels stay the same in aggregate. So even though some beneficiaries will see their costs go up and some will see their costs will go down, the overall out-of-pocket costs for the average beneficiary will stay the same. So am I reading that correctly, that MedPAC doesn't envision or propose any savings from benefit redesign itself?

Mr. HACKBARTH. From the redesign itself, no, sir.

Mr. PALLONE. So in your proposal, isn't it true that the savings come from the tax on first-dollar supplemental coverage?

Mr. HACKBARTH. That is correct.

Mr. PALLONE. And was keeping beneficiary liability neutral an important principle for the commission? Did you want to comment on that?

Mr. HACKBARTH. Yes, it is a very important principle from our perspective. As I said in my opening comment, we don't think the current benefit package is too rich. If anything, it is too lean. Our principal concerns about it are its inappropriate structure. It is not well designed for the needs of the Medicare population, and we think it should be restructured.

Mr. PALLONE. Can you share with us why not cost shifting to beneficiaries was felt to be so important? Do you want to comment on that as well? I know you have to some extent.

Mr. HACKBARTH. Well, as I say, we think for the population served, which is an older obviously somewhat higher-risk population, this is not a rich benefit package compared to what employment-based coverage offers, for example, and so rather than try to achieve savings by cutting benefits, we thought it was better to redesign them. Now, it is possible that if we have a simpler design and one that includes catastrophic coverage that some beneficiaries will choose to forego supplemental insurance over time, and if that happens, we would expect that that might result in lower utilization because there would be most cost sharing at the point of service but it would be the beneficiary's choice to do that.

Mr. PALLONE. All right. Thank you so much. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. Hackbarth, let me just ask you, in a Medicare Advantage system, would a patient buy supplemental insurance for Medicare Advantage?

Mr. HACKBARTH. Typically, they would not. Medicare advantage is offering a different set of tradeoffs, so typically patients have lower cost sharing at the point of service in exchange for agreeing to perhaps network limitations that they are steered to particular providers by the insurer or their benefits are subject to utilization management, you know, prior authorization or other management controls, so that is the tradeoff: lower cost sharing, more management.

Mr. BURGESS. I guess I am having a hard time understanding. It seems like if someone buys a supplemental insurance policy as they enter into Medicare, they are doing the responsible thing by putting some of their own dollars into their future health care by covering against what would be excessive out-of-pocket costs if they get sick. So they are—it looks to me from a physician's standpoint, they are doing the prudent thing. Now, I honestly can't tell you that I ever got a reimbursement check from a Medigap policy, so I don't know. Maybe those dollars never go where they are supposed to. But it looks like the patient is doing the prudent thing with doing that, but you seem to articulate a different opinion.

Mr. HACKBARTH. Well, our view is not for or against the purchase of supplemental insurance. We believe that beneficiaries should have the option of buying supplemental insurance, even first-dollar supplemental coverage, if that is what they wish. We do think that they ought to see more of the costs that result from that private decision. The premium that they pay for supplemental insurance reflects only a fraction of the additional costs that result from that decision.

Mr. BURGESS. But ultimately that is why someone buys insurance, correct, so they are not hit with the entire cost of whatever the event might be that they are insured against.

Mr. HACKBARTH. Yes, but even insuring against this event, they are underpaying for that cost. The right price for insurance should reflect the full cost of the purchasing decision. In the case of supplemental insurance, it does not. It reflects only a fraction of the cost.

Mr. BURGESS. Let me interrupt you because my time is going to run. I don't want to say whose fault is that, but why penalize the poor person who is trying to do the right thing and buying supplemental coverage with their own hard-earned dollars? It doesn't make sense to me to penalize or tax that person additionally if you want them to be bringing some of their own dollars to the system to keep the system solvent.

Mr. HACKBARTH. But we only want for beneficiaries to see more of the cost of the decision that they make.

Mr. BURGESS. I don't disagree with you. I mean, I think we have anesthetized people as to what health care really costs, and that is the argument for the entire health savings account third-party

payment mechanism that is ubiquitous in health care, and perhaps we can talk about that at another time.

When President Obama was doing his charm offensive up here a couple of weeks ago and met with House Republicans down in the basement, I have got to tell you, several years ago in one of the SGR fixes that I have introduced since coming to Congress, and there have been several, but one of them actually did away with Part A and Part B and melded them together. I got a lot of pushback when I introduced that. So I was surprised to hear the president say sort of one of the throwaway lines in answer to a question was, we could combine Part B and Part B. I guess as I further understand it, that was combining the deductibles. But is that a rational approach to dealing with some of these difficulties?

Mr. HACKBARTH. Well, again, we in our recommendation did not specifically recommend a combined deductible. We did recommend catastrophic covers both A and B. On the issue of the combined deductible, we think that actually that is a decision that ought to be part of an overall redesign of the cost sharing in keeping with the principles of value-based insurance design.

Mr. BURGESS. We do of course end up with some people who don't participate in Part B. They have their Part A coverage because of the payroll deduction that they have contributed throughout their working lives. So it is not a completely universal population.

Let me just ask you another question. Cardiologists in this country 4 to 5 years underwent a practice upheaval, and largely because of the administrative pricing brought to them by Medicare. In other words, to do an echo or a treadmill test in the office suddenly was undervalued and it was overvalued, in my opinion, to do that in the hospital, and as a consequence you have seen cardiologists leave their individual practices and be hired by hospitals and insurance companies so that the private practice, solo practice of cardiology has gone away and yet the technology is changing such that, I don't know, NBC has a special on the other night where Dr. Snyderman interviewed Dr. Topol out of San Diego, and with a smartphone and a couple of little adapters, he was able to do an EKG, an echocardiogram and a continuous transcutaneous glucose monitoring. He was providing a lot of care at a very low cost in an office setting but we have kind of actually priced him out of business, have we not, with our administrative pricing in Medicare?

Mr. HACKBARTH. Well, as you know, Dr. Burgess, one of the issues that we are working on currently is synchronizing the payment systems between the hospital outpatient departments and physician offices. So historically, there have been dramatically different prices paid for the same service based on the location, physician office versus outpatient department. That is the problem, and that is skewing incentives, and we think contributing to the migration of physician practices including cardiology practices from outpatient privately owned offices into hospital outpatient departments.

Mr. BURGESS. But I think Medicare was the cause of that rather than the effect, your reimbursement.

I realize my time is up, Mr. Chairman. I will yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member emeritus, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, thank you for holding this hearing and thank you for the recognition, and to our witness, thank you. You have given us very excellent testimony this morning.

As you will recall, it is my practice to ask for yes or no answers. I invite you, if you can, to give us supplemental information as you might deem to be appropriate.

Mr. HACKBARTH. I will try, Mr. Dingell.

Mr. DINGELL. We very much appreciate that.

My old friend Hubert Humphrey once said the moral test of a government is how the government treats those who are in the dawn in life, in the twilight of life and in the shadows of life. Medicare helps our country meet that moral test by ensuring that our sick and elderly have access to care in the time of need. My old dad was one of the architects of Medicare, and it has endured as one of the great and significant pieces of legislation.

Now, Mr. Hackbarth, I want to again express my appreciate for your fine testimony this morning. You note in your testimony that the cost-sharing structure of fee-for-service benefit has remained unchanged since 1965. Is that correct?

Mr. HACKBARTH. Literally, no, it has not. There have been some changes.

Mr. DINGELL. Have there been any really significant changes?

Mr. HACKBARTH. No.

Mr. DINGELL. All right. Would you submit that for the record?

The current fee-for-service benefit has significant cost-sharing requirements for beneficiaries. Is that correct?

Mr. HACKBARTH. Yes.

Mr. DINGELL. Almost 90 percent of fee-for-service beneficiaries have supplemental coverage. Is that correct?

Mr. HACKBARTH. Yes.

Mr. DINGELL. Do you agree that the beneficiaries may choose to have supplemental coverage due to cost-sharing requirements in the current fee-for-service system?

Mr. HACKBARTH. Yes.

Mr. DINGELL. MedPAC has proposed an additional charge on supplemental coverage on Medigap and employer-sponsored retiree plans. Is that correct?

Mr. HACKBARTH. Yes.

Mr. DINGELL. And you have proposed this charge because the commission believes that supplemental coverage leads to increased utilization and spending. Is that correct?

Mr. HACKBARTH. Yes.

Mr. DINGELL. And it would also be fair to say, as you have observed earlier, that it is necessary for us to recoup some of the additional burdens that that imposes on the Medicare trust fund. Is that right?

Mr. HACKBARTH. Yes.

Mr. DINGELL. Do you think that an appropriate charge would be—what do you think would be an appropriate charge on supplemental coverage?

Mr. HACKBARTH. Can I——

Mr. DINGELL. That is not a yes or no answer.

Mr. HACKBARTH. Good. We modeled 20 percent, a 20 percent charge, but we did not recommend a specific number.

Mr. DINGELL. I would appreciate if you would make some additional submissions to us on that point because it is a very important question.

Who would be required to pay this charge? Now, we have some potentials here. Would it be individual policies?

Mr. HACKBARTH. We would impose it on the insurance company, and then it could be passed through in the premium, depending on how the market sorts it out.

Mr. DINGELL. Would it be on employer-sponsored retiree plans?

Mr. HACKBARTH. Yes.

Mr. DINGELL. And would it be applied only to new beneficiaries?

Mr. HACKBARTH. No.

Mr. DINGELL. Would it be applied to everybody?

Mr. HACKBARTH. Yes.

Mr. DINGELL. I know the Administration seems to be saying that these charges will be applied only to new beneficiaries after 2017.

Mr. HACKBARTH. Yes.

Mr. DINGELL. Do you agree that the supplemental charge would cause Medicare beneficiaries to face additional cost sharing? Now, you have some comments on that. Do you want to amplify on that?

Mr. HACKBARTH. Could you just repeat it again?

Mr. DINGELL. OK. Do you agree that the supplemental charge would cause Medicare beneficiaries to face additional cost sharing?

Mr. HACKBARTH. Well, certainly the supplemental charge itself would be an additional cost. How beneficiaries would respond to that is difficult to predict. What we think would happen is, the current beneficiaries may not change their choice of policies as significantly as new beneficiaries coming into the program over time.

Mr. DINGELL. Now, you have indicated that you don't intend to increase the burden on the population of beneficiaries generally. Am I correct in that?

Mr. HACKBARTH. In our benefit redesign?

Mr. DINGELL. Yes.

Mr. HACKBARTH. No. We went to hold that constant.

Mr. DINGELL. Now, do you agree that the supplemental charge could cause some beneficiaries to drop or reduce their supplemental coverage due to the additional charge?

Mr. HACKBARTH. We that it may cause some beneficiaries to change their choices. As you well know, there are a wide range of supplemental plans. Some have front-end cost sharing; some do not. So there might be a move from first-dollar supplemental coverage to policies that have some cost sharing at the point of service.

Mr. DINGELL. Now, I have to think that a charge on supplemental coverage could result in Medicare beneficiaries not seeking out the services and care they need or delaying treatment or care until it is too late. I think that is a potential risk but first, is it a risk, and second, what do we do about it?

Mr. HACKBARTH. It is a risk, and this is why we think it is very important to give the Secretary to the authority to adjust cost sharing based on the principles of value-based insurance design. In other words, reduce cost sharing for services of proven high value

to patients and perhaps increase cost sharing for low-value services.

Mr. DINGELL. So you are suggesting the Secretary should have authority to adjust those charges but that should be subject again to requirements in law that would say he can't necessarily change the overall structure to create a disadvantage to the population. Is that right?

Mr. HACKBARTH. Exactly.

Mr. DINGELL. Mr. Chairman, I have gone over time.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman.

I was intrigued with your testimony in regard to secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, and I was wondering if you could expand on that because one of my concerns would be, I understand if something has a high benefit, lowering that cost pay, but you could theoretically raise the copay so high that people couldn't afford it, even if they really wanted to do that, and I am concerned that for a particular patient and a particular doctor, they may make a decision that perhaps universally might not have great benefit but could to that patient. I was wondering if you could expand on that. My thought was, maybe put caps on the high end.

Mr. HACKBARTH. So as you know, a number of private insurers and employers have been moving towards the idea of value-based insurance design. Typically, the focus has been on reducing patient copays for services of high proven value. An example would be having low copays for services provided to diabetics or patients with multiple chronic illnesses to make sure that they get the care they need to prevent worsening of their health and potentially higher bills as a result of that. There has been less done in terms of increasing copays for low-value services, probably for the obvious reason that there is more controversial than reductions are. So I would anticipate that at least initially most of what the Secretary might do with this authority is lower copays. That said, there are services that sometimes can be quite expensive but are of low value to patients, and rather than prohibit access to those services and say oh, you are a Medicare beneficiary, you can't have that service at all, the idea would be to say oK, you can have it but you are going to pay a bit more of the cost of that service if it is a proven low-value service.

Mr. GRIFFITH. And I don't come from a medical background. Can you give me an example of one of those that across the country would have low benefit and might need to have the fee raised?

Mr. HACKBARTH. Since I am not a physician either, I would be reluctant to do that. What I would say is that, you know, this should be done thoughtfully and will be done as part of a notice and comment rulemaking process so the Secretary would have to publish the evidence to support this low-value assessment, and all relevant parties would have the opportunity to contest that evidence and respond to it, and I think that is the way it ought to be decided by experts, not by people like me.

Mr. GRIFFITH. As a representative of the public, and while I generally think experts do a pretty good job, sometimes I have big dis-

agreements with them and I would just have to say that while I kind of like the idea, Mr. Chairman, I would want to see—if we were to authorize the Secretary to do that, I would want to see some kind of a cap on the top of the—as a top number so that you wouldn't be in a position where suddenly a procedure is completely voided because the cost is just so horrendous that nobody can justify it except for the extremely rich. So I do appreciate that.

With that, Mr. Chairman, I will yield back my time.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Utah, Mr. Matheson, 5 minutes for questions.

Mr. MATHESON. Thank you, Mr. Chairman, and thank you, Mr. Hackbarth, for being here today.

It seems to me that one of the outcomes of your suggested change in this benefit design has something to do with overutilization and trying to address that issue in terms of having the individual patient have a little more of a consumer orientation. Is that a fair assumption?

Mr. HACKBARTH. That is part of it, Mr. Matheson, but the most important part from our perspective is to improve the benefit package for beneficiaries including catastrophic coverage.

Mr. MATHESON. I wanted to talk a little bit about a particular component of overutilization. I may be getting a little off the specific benefit design topic of this hearing, but I know in your MedPAC March report you identified some specific geographic areas where there is a strong reason to believe that certain inappropriate billing practices are at play in the home health care industry, and I have seen some data that is pretty phenomenal in my mind. I compare my State to Miami-Dade County. I got 190,000 Medicare beneficiaries in Utah. There are about that many in Miami-Dade County. However, there is 700 home health care providers in Miami-Dade County and about 100 in Utah. Home health services in Utah cost Medicare a lot less than the services performed in Miami-Dade. The average cost per enrollee in Utah is $560. The average cost in Miami-Dade County per enrollee is over six times that amount of $3,500. It strikes me that the vast majority of providers in the home health care industry in Utah are doing the right thing, and it strikes something is going on in Miami-Dade County that doesn't pass the smell test, and it seems to me that it is an important issue for us to look at in how we try to seek out these pockets of geographic areas where there is this huge overutilization going on and instead of doing a policy that may affect all providers including those that are doing the right thing that we target those who aren't. So in the instance of home health care, I was wondering, would it be better for Medicare in terms of saving money and decreasing overutilization to scrutinize the issue of new provider numbers or to look at reasonable limits on episodes of care in these high utilization areas like Miami-Dade County?

Mr. HACKBARTH. There are two types of problems in home health care as we see it, but before I focus on the problems, let me emphasize that we think that good home health care is an essential part of good quality care for Medicare beneficiaries.

Mr. MATHESON. And I agree.

Mr. HACKBARTH. So in no sense are we against home health care, but there is, as you say, evidence that in some parts of the country

we have extraordinary levels of use and extraordinary number of home health agencies and we think indications of fraud and abuse, and we have made recommendations for targeted efforts to deal with those problems including limits on the number of new agencies in those problem areas, so we think that is an important thing to do.

Having said that, though, across the country, we believe, even in the low-use States we are paying too much for each episode of home health care. So even where there isn't that fraud and abuse, we believe the rates are too high relative to the costs incurred.

Mr. MATHESON. In terms of this situation where you have got some certain geographic locations where there appears to be extremely high overutilization compared to a peer comparison elsewhere, is it reasonable to assume that this situation is occurring in other aspects of Medicare services in this country outside of home health care?

Mr. HACKBARTH. Well, quite possibly, yes. Another area where we see extreme variation is durable medical equipment. So post acute care in general which includes home health care and DME account for a significant portion of the geographic variation that is the focus of so much attention in Medicare.

Mr. MATHESON. We feel like in our State, we practice medicine in a way that if the rest of the country did it, we would be saving a lot of money with outcomes just as good, and so I think this is something, Mr. Chairman, I know it is a little outside of the benefit structure of this hearing today but this issue of disparate discrepancies in utilization across different geographic areas is something I think is worthwhile for us all to take a look at and provide some real opportunity for some savings. With that, I will yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman, and I would like to follow up a little bit on what my friend from Utah was talking about, because you have talked about and you mentioned again the high margins in home health, and I know home health, in my understanding, has been cut, what, 21 percent since 2010 and for publicly traded home health—that is the information I was able to get—before tax margins in 2009 were 13.4 percent, in 2012, 3.9 percent. I think there is four publicly traded. And after tax margin in 2012 was 2.5 percent. So it seems like if you had more in Miami, you would get better competition, so it is kind of counterintuitive how that works.

And I guess my question is, you have a report that had the margins. What was your methodology in that report?

Mr. HACKBARTH. We used Medicare cost reports, so in contrast to the publicly traded companies, what we are looking at is Medicare-specific profit margins whereas for a publicly traded company, we would be getting a combination of Medicare margins and margins on private insurance as well.

Mr. GUTHRIE. OK.

Mr. HACKBARTH. So it is an apples-to-oranges comparison.

Mr. GUTHRIE. Well, thanks for that. On the supplementals, so you were saying the number you have suggested—I know you

didn't recommend it—is 20 percent, or looked at 20 percent should be actually added to the—you said charge to the insurer but the premium should be 20 percent higher to reflect the true cost to the taxpayer for buying supplemental——

Mr. HACKBARTH. Yes, so the example that we modeled was a 20 percent charge that would be imposed on the insurance. How that would affect the premiums would depend on, you know, market competition and different markets. In some cases, it might be all passed on. In other words, it might not be.

Mr. GUTHRIE. So the additional cost that you are trying to capture is what the supplemental policy does in terms of utilization?

Mr. HACKBARTH. Increased utilization, so our analysis shows that beneficiaries that have supplemental coverage use about one-third more services after adjusting for differences in age and risk, etc.

Mr. GUTHRIE. Because the more likely you are to use the system, the more you—so the sicker you are, the more likely you are to buy a supplemental policy?

Mr. HACKBARTH. But in our analysis, we adjust for risk.

Mr. GUTHRIE. Well, thanks. I yield back my time.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Green, for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. Hackbarth, thank you for appearing today, and again, thank you for a lot of the information we worked on for many years. MedPAC's proposal for benefit redesign is careful to point out that aggregate beneficiary cost sharing would be kept the same. You point out in your testimony that the reason for this is the commissioners' judgment that traditional Medicare's benefit structure is not too rich, especially for the population covered. One of your goals is to protect the beneficiaries against high out-of-pocket spending while not reducing the actuarial value of the benefit package. Can you explain what you mean by the benefit package not being too rich?

Mr. HACKBARTH. Right. So a way to judge the richness of a benefit package is, what percentage of a patient's costs are paid through insurance as opposed to out of pocket. Using that as the standard, we don't think that the percentage paid by Medicare of total beneficiary costs is too high. In fact, if anything, it may be too low. So we accepted as a starting point that we ought not be cutting the amount paid by Medicare that would put too much of a burden on beneficiaries. We felt like there were a lot of things we could do to make the package better including providing catastrophic coverage and making it simpler. We thought that those changes in turn might cause some beneficiaries to say, you know, I don't need to pay $175 or $200 a month for supplemental insurance, which is a big burden on many beneficiaries as well.

Mr. GREEN. Frankly, in our area, $175 or $200 a month is pretty small. I have seen some quotes for that.

Now, switching gears. A lot of attention has been given to supplemental insurance plans like you just mentioned in Medicare, particularly those provided by employers or Medigap plans purchased by individuals. There is a lot of concern about Medicare patients not having enough skin the game, so to speak, because their supplemental policies often pick up deductibles, copays and coin-

surance. As I understand your proposal, charging or paying a premium for this first-dollar supplemental insurance is intended to offset the cost of some of the other benefit design changes?

Mr. HACKBARTH. Well, the overall package that we modeled including the catastrophic coverage and the new structure of copays would have resulted in a modest increase in Medicare expenditures, about 1 percent, and so in our package we combined that modest increase with this 20 percent charge on supplemental insurance and the net result of those two things would be a modest reduction in total Medicare expenditures of about one-half of 1 percent.

Mr. GREEN. I understand that correctly. Is it true that cost sharing reduces both necessary and unnecessary care?

Mr. HACKBARTH. Yes. That is what the evidence shows, and that is why we think that giving the Secretary the authority to do smarter cost sharing, not just across the board but targeted based on value is so important.

Mr. GREEN. And I understand that we want patients more active in their decisions on their care but that may work for some of us that are younger elderly patients but a lot of our older patients how are sicker, they just may take a more passive role in their care and their decision making, and Mr. Chairman, I remember I was a State legislator in the 1980s and we had a Senator from Texas, Lloyd Bentsen, who worked on trying to do catastrophic and reform Medicare, and somehow the seniors got Congress's attention, and I remember talking to Senator Bentsen at that time and he said we just went too far for what our seniors would accept, and it was, you know, a revolution by those under Medicare almost in the late 1980s.

Mr. HACKBARTH. In fact, I worked in what was then HCFA, the Health Care Financing Administration, during that period, so I remember it well.

Mr. GREEN. And I understand, Mr. Chairman, there are some good parts of this but we need to look at it because a lot of seniors would like not to have to have that high monthly premium for their Medigap coverage, if we could somehow equal it out.

Mr. HACKBARTH. And unfortunately, I think the current structure without catastrophic coverage almost compels seniors to pay that high monthly premium for supplemental insurance because the Medicare package does not offer them the most basic feature of a good insurance plan, an out-of-pocket limit.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Ms. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman.

Mr. Hackbarth, I have a document here which is basically a list of bipartisan quotes from both conservative and progressive authors relevant to the proposals, many of which you are proposing today, and I will just say that drawing from it, President Obama's National Commission on Fiscal Responsibility and Reform released in 2010 quoted—this is a quote taken from that bit of information: "Currently, Medicare beneficiaries must navigate a hodgepodge of premiums, deductibles and copays that offer neither spending pre-

dictability nor protection from catastrophic financial risk. The ability of Medicare cost sharing to control costs either under current law or as proposed above is limited. Do you believe—and I think you can probably just give a yes or no answer to this. Do you believe that MedPAC's reforms ad they encourage more predictable out-of-pocket costs and limit on catastrophic costs may allow seniors to better plan for balance in their future health care and financial needs?

Mr. HACKBARTH. Yes.

Mrs. ELLMERS. Thank you. In 1995, Henry Aaron of the Brookings Institute and Robert Reischauer of the Urban Institute had this to say about combining Medicare Part A and Part B: "Whatever rationale may once have existed for the distinction between services and Part A and Part B medical technology, the development of new reforms and service delivery and new patient structures have rendered it obsolete." I raise this point because we think it is important as part of the conversation today that we all understand that Medicare traditional benefits are obviously outdated and cause unnecessary harm for our seniors as a result. There again, in your opinion, yes or no, do you believe the concept of combining Part A and Part B is a good Medicare idea?

Mr. HACKBARTH. Yes. As I said earlier, our recommendation is for a combined A and B catastrophic limit. We have not specifically recommended an A and B combined part.

Mrs. ELLMERS. And do you believe that the concept of this can be characterized as a Republican idea?

Mr. HACKBARTH. Well, this package that I have described today was unanimously recommended by the members of MedPAC, 17 members of various political persuasion.

Mrs. ELLMERS. So basically you would have to say no then?

Mr. HACKBARTH. We are a nonpartisan agency and we really try to live up to that billing.

Mrs. ELLMERS. To be bipartisan. OK. The AARP's Public Policy Institute had this to say about the traditional Medicare benefit designed in 1999: "Medicare, widely considered to have been successful in improving access to care and lessening the financial burdens of health care for older Americans, is also viewed as a program in need of a more updated management structure. The two-part system that drives many of its payments and revenue policies almost certainly would not be adopted if the program were being designed today. The current design reflects some factors that while relevant when Medicare was initiated in 1965 are not now pertinent." In your opinion, do you believe that the current design of Medicare traditional benefits reflects some factors that may have been more relevant in 1965 as opposed to now, 2013?

Mr. HACKBARTH. Yes.

Mrs. ELLMERS. Wonderful. I have a couple minutes. We are going to be taking part—Congresswoman Marsha Blackburn and I are going to be taking part in a committee idea lab, basically just bouncing some ideas and thoughts, after this hearing. Some of the proposals outlined by MedPAC will be included in our proposal and some of the questions we are going to be taking. I look forward to working with this committee over the next months to explore these ideas and push forward meaningful Medicare reforms that serve

the best interest of Medicare seniors, and at this time I would like to ask unanimous consent to insert into the record this piece of information that we have here, this review of bipartisan support.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mrs. ELLMERS. Thank you, Mr. Chairman, and I yield back the remainder of my time.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentlelady from Virgin Islands, Dr. Christensen, for 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you, Dr. Hackbarth, for coming back to the committee. I appreciate MedPAC's recognition of the need for added protections, particularly with regard to the out-of-pocket spending caps in your benefit design proposal, and I think I understand but don't necessarily agree with some of the ideas behind the proposed reform of supplemental or Medigap coverage, but I am very concerned with the level of support and protections for low-income seniors and that analyses done on the impact of seniors as a group may not adequate capture the impact on those that are most vulnerable. Every study that I have reviewed looking at the impact of the cost sharing on patients and patient behaviors concludes the same thing, that patients use less services but do not differentiate between necessary and unnecessary and that those that are poorer and sicker are the most cost-sensitive and would be the ones that would reduce the use of services the most.

So as you know, the Medicare beneficiaries are poorer and sicker than the population at large. Twenty-three percent have a cognitive or mental impairment. Forty percent have three or more chronic medical problems. About half of the beneficiaries have annual incomes below 200 percent of poverty level, and one-quarter have incomes less than $14,000 per year. So these beneficiaries are very much the patient population that is at greatest risk for reducing the use of necessary medical services or deferring important care that results in a preventable hospitalization, and I know you have thought about these issues because your proposal builds in protections for those currently covered by Medicaid. What about the other low-income seniors and the ones, the 40 percent with multiple chronic diseases for whom we don't really want to create additional barriers to care.

Mr. HACKBARTH. So Dr. Christensen, I agree basically with your summary of what the evidence shows about cost sharing, and so I want to emphasize again, our goal is not to increase the average level of cost sharing but redesign the benefit to make it better for Medicare patients and perhaps reduce the need for them to buy supplemental coverage. We think that using value-based insurance design is very important to get at some of the issues you have identified. We don't want to increase cost sharing on really high-value services, for example, for chronically ill patients. In fact, we may want to reduce cost sharing on those.

With regard to the impact on low-income people, we think that there are targeted approaches to dealing with that issue that are better than what we now have. Right now, what we have is a system whereby in effect the taxpayers are providing an implicit sub-

sidy for the purchase of supplemental coverage because the taxpayers pick up most of the bill for the added cost. That subsidy goes to all beneficiaries rich and poor alike. If the particular concern is low-income beneficiaries as well at might be, a more targeted way to deal with that issue would be to expand eligibility for the Medicare savings programs. So right now Medicare beneficiaries that have incomes less than 100 percent of poverty qualify to get their Part B premiums and cost sharing paid under Medicaid, but above that level, there is no contribution for offsetting cost sharing. Up to 135 percent of poverty, there are subsidies for the Part B premium but you still have to pay the cost sharing. So if Congress is concerned about low-income people and the impact of this on low-income people, a much more targeted approach would be to change eligibility for the Medicare savings programs, and I would note that the low-income subsidy under Part D has higher income thresholds for eligibility than we have in the Medicare savings programs for Part A and B, so there is already a precedent, if you will, for higher levels of eligibility.

Mrs. CHRISTENSEN. Thank you for that. That gives us some idea of where to go.

You talk a lot about giving the Secretary flexibility to set copays for high value versus low value, and I have been following the Patient-Centered Outcome Research we created in the Affordable Care Act, and I am wondering, do you see that as being helpful, their work as being helpful to identify high volume, low value in that process?

Mr. HACKBARTH. Yes. A number of years ago, before the Patient-Centered Outcome Research Institute was created, we recommended to Congress that such an organization be created and that the federal government support the development of better information for physicians and patients about what works, and so to the extent that PCORI can increase the knowledge base that we have, that is information that could be used in value-based insurance design.

Mrs. CHRISTENSEN. Thank you. Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The Chair thanks the gentlelady and recognizes the gentlelady from Tennessee, Ms. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you so much. We appreciate that you are taking the time to be here, and as Ms. Ellmers said, we are going to be spending some time looking at how you do help with the solvency, and I want to ask you just one thing. My class, when we came into Congress, we were focused on waste, fraud and abuse. We did an entire project, Wasteful Washington Spending, and of course, Medicare spending continued to come into that picture, and we had example after example of wasteful and fraudulent spending and the abuse of just millions of dollars. So do you think, in your opinion, do you think that the antiquated method, the fee-for-service method, is something that continues to make it possible for this continuation of waste, fraud and abuse every year and difficulty in running the traps on this and rooting it out?

Mr. HACKBARTH. Yes. We think that waste, fraud and abuse is a significant problem, particularly in some areas of the program.

Earlier we were talking about home health care is an area where there is a lot, and where Medicare payments are really generous, and we think they are generous for home health care, that is almost an invitation to people who want to make a quick buck on Medicare.

Mrs. BLACKBURN. A lot of quick bucks, it seems like.

Mr. HACKBARTH. A lot of quick bucks, and durable medical equipment is another area where we think there has been a fair amount of waste, fraud and abuse, and in part that is triggered by very attractive payment rates that bring in people who are more focused on making money than serving patients.

Mrs. BLACKBURN. What would you say is the percent of expenditures that are going out the door, those payments going out the door? What percent do you think are fraudulent payments?

Mr. HACKBARTH. We really haven't looked at that issue. I think the Government Accountability Office has made estimates that——

Ms. BLACKBURN. Right. They have. I just didn't know if you kind of lined up with them or if you had another opinion of that.

Let me ask you, looking at that same thought and thinking about the solvency and the financing mechanisms, AARP has done reports going back 1998, 1999 looking at merging A and B and then looking at the financing end of that. Where do you stand with those knowing that people are concerned? We hear about it every day—tell me what you know is going to happen with Medicare, are we really in danger of going bankrupt. And so as you put your reforms forward today, what do you think they will do in helping with the solvency? If we did your reforms, how long would it encourage the solvency of Medicare? How many more years would we get out of this?

Mr. HACKBARTH. Well, that is a question better directed to the Medicare actuaries. What we have outlined is a package that would have a modest net reduction in Medicare spending on the order of about one-half of 1 percent so that, you know, $2.5 or $3 billion a year, $25 or $30 billion over 10 years. Now, what that assumes is a 20 percent charge on supplemental insurance and that nobody modifies their decisions, beneficiaries don't change their decisions about purchasing supplemental insurance. If in fact beneficiaries start to say, oh, this new redesigned benefit means I don't have to buy supplemental insurance or they buy one that doesn't have first-dollar coverage, then those savings may increase and you might go from $2.5 to $3 billion a year to $5 or $6 billion a year.

Ms. BLACKBURN. Well, yes, and that is always kind of the discussion we get into with whether we are using the static or the dynamic scoring ad the basis that people make their decisions on.

I have one other question, but in the interests of time, Mr. Chairman, I will yield back my time and submit my third question.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Maryland, Mr. Sarbanes, for 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman. Thank you, Mr. Hackbarth.

Could you just talk a little bit about the relationship between the proposed benefit design change that would impose a higher cost-sharing impact on a patient for a lower-value service and a lower

cost share for a higher-value service, the relationship of that proposal to the change in reimbursement methodology vis-&-vis the providers of care, which is another place where we are looking at this high-value, low-value dynamic? In other words, you have services now that a primary care physician might be prepared to offer but there is really no meaningful reimbursement for it so there is no incentive to do it so you can envision a situation where there is a service that is not getting covered at all by Medicare and maybe want to re-look at that but then at the same time we want to examine then what the cost sharing with Medicare's new obligation would be. It seems to me those have got to be interrelated to some degree.

Mr. HACKBARTH. So we think there are issues on both the patient cost-sharing side and the provider payment side, and I think at the SGR hearing a few weeks ago, the two of us talked about primary care services, which we think are high-value services that are often are underpaid under the existing Medicare fee schedule. So in the case of a primary care who has taken responsibility, for example, under a medical home to manage patients with multiple chronic illnesses, you know, ideally what you might have is lower cost sharing for really high-value services for the patient and richer payment for the physician for taking on this very important task of managing complicated patients. Right now, Medicare has fallen short on both the provider and the beneficiary side.

Mr. SARBANES. In that sense, it is kind of a double investment in redirecting or transitioning the emphasis of where the care happens and has to be premised on the idea that even that increased investment, which is a combination of higher reimbursement to the physician and lower cost sharing on the part of the patient, that we are going to see, it is going to yield savings down the road that justifies both of those investments we are making.

Mr. HACKBARTH. Yes. Ideally, we are working both sides, the provider payment and the beneficiary benefit structure, and doing it in a synchronized way. That is how we get the maximum impact.

Mr. SARBANES. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. Hi, Mr. Hackbarth. I will kind of scoot over so we can see each other.

I always enjoy your testimony. I always consider it very thoughtful.

Now, there does seem to be, though—I always make the point that people in Washington have kind of a centrally planned economy view of how we do things, and if you will, as great as your work is, it truly is trying to anticipate lots of very unique situations coming up for rules that with that anticipation work to very unique situations. The very premise seems untenable. Do you see my point?

Mr. HACKBARTH. Well, yes and no. On the one hand, I do believe, and I think we have talked about this in the past, that giving Medicare beneficiaries options, for example, to enroll in a Medicare Advantage plan, a private health plan, is a very important thing to do, and I think you agree with that as well. On the other hand,

I must confess, when I hear people criticize Medicare for its administered price system, it sets me a little bit on edge because I know better than most people the problems with administered prices. I have spent many, some would say too many hours working on these issues in my career. But when I look at Medicare pricing compared to pricing in the private sector, our system looks pretty good.

Mr. CASSIDY.No, believe me, I am not defending the private sector, and I actually like your proposal that if you put these physicians at two-sided risk with some sort of accountability as to outcomes and have the quote, unquote, activated patient, that is the better way to go. My concern is that if there is an innovation which is disruptive, it gives you a better outcome at a lower cost. It will be 3 years later before that may be priced accordingly or even given a code.

Mr. HACKBARTH. And, you know, overall, my goal is to decentralize decisions, put as many decisions as possible in the hands of physicians and patients, provided that there is accountability for the results, both quality and cost.

Mr. CASSIDY.Now, a conversation just to revisit we have probably had before, the ACO, I think you rightly put the physician-patient relationship at the center of our ability to improve outcomes and control costs. But I see a lot of what we are proposing are actually on the suprastructure, if you will. Here is the patient, physician, but here is the administrative cost and here is the ACO, etc., and that actually seems to be insulating or denying responsibility for this integral relationship. Any thoughts on that?

Mr. HACKBARTH. Well, so let us use ACOs as a potential framework for decentralizing decisions to physicians and patients, and as you know, from prior conversations, I believe in that. You know, right now we have got an ACO structure which I think is a step in the right direction but has some problems with it, and one that I would highlight in this context is, Medicare beneficiaries don't share in any of the savings from an ACO. All of the talk is about how the physicians, the hospitals and the government share in the savings but there are no real rewards for Medicare beneficiaries. We think across the board we need to work on improving provider payment and bringing Medicare beneficiaries appropriately into those discussions and allowing them to share in savings when they go to high-value providers.

Mr. CASSIDY.And we are totally in agreement on that. I think one thing I would also point out is that if we are going to bring this down to the smaller practice, I am not quite sure how an ACO would work for a four-person practice in a rural area, if only because you are only going to get settled up on the positive things you have done 2 years after you have done it. If you are in a cash-flow-dependent practice, you probably don't have the wherewithal to wait 2 years to have a settling up.

Mr. HACKBARTH. Although one of the ACO models does involve an advanced payment for just that reason, the physician-sponsored ACOs. You know, I think it is too early to predict exactly how ACOs will develop, especially in sparsely populated areas like rural areas, but about half of the current ACOs involve either Critical

Access Hospitals or Community Health Centers and deal with relatively challenging care delivery systems.

Mr. CASSIDY.I accept that, but we are going so far down the road in terms of planning and implementing political and bureaucrat capital in putting these in place. Not knowing where they are going to go and seeing that there are flaws inherent in them makes me troubled. I mean, is that unique relationship going to be preserved when, again, we just don't know where it is going.

Mr. HACKBARTH. Well, we certainly believe that preserving that relationship is really important, vital, essential, and I may be a little bit more optimistic than you are that in fact the movement is in the right direction, but I think we have to be vigilant about it.

Mr. CASSIDY.I am out of time. I yield back. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much.

Mr. Hackbarth, your testimony really touches on the importance of transparency and predictability in pricing and out-of-pocket expenses for seniors in the Medicare program. No other industry I know of would facilitate customers not knowing the cost of service until after it has been performed. Can you explain your thoughts on the importance of out-of-pocket predictability as it relates to the reforms you have presented here today or even for future reforms to the program?

Mr. HACKBARTH. Well, Mr. Bilirakis, the most important thing is that we know from focus groups with beneficiaries that they find the current benefit structure confusing and more than a little bit frightening because they don't feel like they can predict what is going to happen, what the bill is going to be if they get sick or even when they go to a physician office because, as Dr. Burgess said, it is 20 percent of what. We don't know. And so what we have advocated is a focus on simplification and protection against overall costs, and we think that that will be very reassuring to Medicare beneficiaries and perhaps over time will influence their decisions about whether they need supplemental insurance and, if so, what kind they buy, and that would be a good thing for Medicare.

Mr. BILIRAKIS. And you of course agree that seniors should be more active participants?

Mr. HACKBARTH. Absolutely.

Mr. BILIRAKIS. Thank you. You reference in your testimony, and I think the gentlelady from the Virgin Islands referred to this, but your testimony, the suggestion that Congress should consider giving the power to the Secretary to reduce cost sharing on services if evidence indicates that doing so would reduce Medicare spending or lead to better health care outcomes, and vice versa. Can you elaborate on that?

Mr. HACKBARTH. Well, I am not sure I have a whole lot new to say on that, but we do think that services are of different value to patients. Certainly we know that some services are really important for beneficiaries with chronic illness, and we don't want cost sharing at the point of service to be a barrier to that care because patients will be worse off with worse health outcomes, and Medicare will incur higher long-run costs. And so as opposed to a crude

approach to cost sharing which just says same rate for everything, you know, 20 percent across the board, we think we can do better than that and be smarter about it and have better results for patients.

Mr. BILIRAKIS. Thank you very much. I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman. I would be happy to yield my time to Dr. Burgess.

Mr. BURGESS. I thank the gentleman for yielding.

Mr. Hackbarth, just a couple of follow-up things, and thank you for mentioning HCFA. It brought back memories of when I thought HCFA was a four-letter word when I was in practice. Back in the 1990s with the passage of the Kennedy-Castelbaum bill, that behemoth that gave us HIPAA, but it also allowed for the first time the sale in this country of medical savings accounts, but if I recall correctly, they were very careful to keep that type of insurance out of the Medicare system. Is that correct?

Mr. HACKBARTH. Yes, I think that is correct.

Mr. BURGESS. Well, here is my question, and I still have a problem with the concept that—and let me very honest with you here. I have got someone in my household who is going to turn 65 this year, and we are just deluged with stuff from people wanting to sell a supplemental policy. So I can certainly sympathize with the person who looks at all of this information, and oh, my god, I want to do the right thing, I want to be prepared for bad things that could happen so I will make this investment. It is hard for me to believe that that is an erroneous activity for that person for them to be engaged in that. You kind of indicate in your testimony that a lot of times what they are paying in for that supplemental is far in excess of anything they would get from a benefit from the supplemental payment. Why don't we make it easy to put additional dollars away for their health care in a Medicare health savings account that would be available them to draw on and need if there were costs over and above what the Medicare benefit would provide them?

Mr. HACKBARTH. Dr. Burgess, we haven't looked specifically at the issue of medical savings accounts for Medicare beneficiaries, so I don't have a MedPAC view on that.

Mr. BURGESS. Let me just offer you an observation. We talk about 10,000, 12,000 people a day entering Medicare. There are going to be more and more people who enter Medicare with a health savings account that actually has cash in it that was not used prior to the time of entering into Medicare. Are you looking over the horizon at all and trying to figure out how do you deal with—Bill Cassidy called them the activated patient. That is exactly right. Governor Mitchell Daniels when he provided his Healthy Indiana program to State employees essentially was a high-deductible health plan coupled with a health savings account, he made the observation that something magic happens when people spend their own money for health care, even if it wasn't their own money in the first place. But you have got these people arriv-

ing into Medicare, aging into the Medicare system with a large health savings account that they are holding. Why not allow them to participate in their care?

Mr. HACKBARTH. Well, this is an issue of personal interest since I am going to be 62 and actually my wife and I have a health savings account. We have been insured under a high-deductible plan for quite some time now. So it is an important issue. It is not one that we have looked at at this point.

Mr. BURGESS. Let me just make another observation. I mean, I know fee-for-service gets a bad name and a bad rap in a lot of ways, and Dr. Cassidy referenced the small practice in rural setting. I always allude to the solo practitioner in Muleshoe, Texas, who really can't participate in an ACO. Yes, they can be acquired by a network. But, you know, every time I think of accountable care organizations, I have to ask myself, accountable to whom, because as Dr. Cassidy correctly pointed out, there are significant—because of the risk factor, there is a significant cash amount that needs to be available that is generally not available to the small and individual practice so that there is someone else who is going to have to be, if you will, a financial or fiscal partner in that endeavor. So it just begs the question, accountable to whom? Is it accountable to the hospital? If the doctor is accountable to an accountable care organization, is that really accountable to the hospital or to the government or to a health plan? It kind of begs the question, are they still accountable to the patient, and just speaking from a professional standpoint, I am worried about the direction in which that is going.

Mr. HACKBARTH. Well, there are to be sure lots of complicated issues that need to be examined and resolved around the development of ACOs. I think it is a step in the proper direction. I say that because I really am looking for structures that decentralize decisions so that clinicians and patients can make them together subject to accountability on quality and cost. Now, exactly how you set the cost and all the issues about the flow of the money, those are really important things, and I don't mean to diminish their importance, but if the goal is getting the federal government out of intrusion into medical practice, structures like this I think need to be part of the solution so let us focus on making them better as opposed to undermining them.

Mr. BURGESS. Thank you, Mr. Chairman. I will yield back, and I thank the gentleman from New Jersey for yielding the time.

Mr. PITTS. The Chair thanks the gentleman. We have a unanimous-consent request.

Mr. PALLONE. Mr. Chairman, I ask unanimous consent to submit for the record various statements from the United Steel Workers, California Health Advocates, testimony on behalf of the UAW, a statement from the National Association of Home Care and Hospice, and a statement from the National Committee to Preserve Social Security and Medicare, and I believe you have all these.

Mr. PITTS. Yes. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. That concludes the round of questioning. We have some members who have additional questions. I remind members they have 10 business days to submit any additional questions for

the record, and I ask the witness to please respond to the questions promptly.

Thank you very much for your time, your testimony this morning. And members should submit their questions by the close of business on Thursday, April 25.

Thank you, and without objection, the subcommittee is adjourned.

[Whereupon, at 11:39 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

IDEAS FOR REFORMING THE MEDICARE BENEFIT DESIGN:
A HISTORICAL YEAR REVIEW OF BIPARTISAN SUPPORT

"Regardless of the magnitude of changes enacted, creating a unified structure would be consistent with aligning Medicare with changes in health insurance that have occurred since the program's creation. Indeed, **a unified structure may be necessary to offer Medicare more flexibility to provide access to affordable, high quality car**e in a continually changing health care environment.

- AARP Policy Institute. *"The Effects of Merging Part A and Part B of Medicare."* C.F. Caplan, D.J. Gross. 1999

"Under the plan, the traditional Part A and Part B fee-for-service deductibles would be combined...this **will lower the hospital deductibles**."

- National Bipartisan Commission on the Future of Medicare. *"Talking Points: Breaux-Thomas Proposal."* 1999

"**Currently, Medicare beneficiaries must navigate a hodge-podge of premiums, deductibles, and copays** that offer neither spending predictability nor protection from catastrophic financial risk. ... The ability of Medicare cost-sharing to control costs – either under current law or as proposed above – is limited by the purchase of **supplemental private insurance plans (Medigap plans) that piggyback on Medicare**."

- The National Commission on Fiscal Responsibility & Reform. "The Moment of Truth." December 2010.

"Congress should begin a two-stage structural reform of Medicare to transform the program into a robust system of consumer choice and competition...**Medicare's fee-for-service (FFS) financing is cumbersome, counterproductive, and wasteful.** It generates patient access problems and dissatisfaction among doctors, and it rewards volume rather than quality. Even with price controls, Medicare spending accelerates, thus fuelling larger deficits. Congress can make real progress with specific policy changes...[by] Protect[ing] Medicare patients from the costs of catastrophic illness; and Cut[ing] taxpayer subsidies for the wealthiest beneficiaries."

- The Heritage Foundation. "The First State of Medicare Reform: Fixing the Current Program," 2011

"Looking to the future, **Medicare faces a number of challenges, including: An outdated benefit design, with relatively high deductibles and cost-sharing requirements**, no limit on out-of-pocket spending, and benefit gaps, that encourages beneficiaries to seek supplemental insurance and contributes to relatively high out-of-pocket spending."

- Kaiser Family Foundation (Author panel includes experts from the American Enterprise Institite, the Commonwealth Fund, the Obama Administration, Brookings, and the Urban Institute). "Policy Options to Sustain Medicare For The Future." January 2013.

"Medicare Parts B and D, certain beneficiaries pay higher premiums based on their higher levels of income. Beginning in 2017, **this proposal would restructure income-related premiums under Medicare Parts B and D** by increasing the lowest income-related premium five percentage points, from 35 percent to 40 percent, and also increasing other income brackets until capping the highest tier at 90 percent."

"Introduce Part B Premium Surcharge for New Beneficiaries Purchasing Near First-Dollar Medigap: This proposal **would introduce a Part B premium surcharge for new beneficiaries who purchase Medigap policies with particularly low cost-sharing requirements**, effective in 2017."

- U.S. Department of Health & Human Services. "Fiscal Year 2014 Budget in Briefing," 2013

Submission for the Record to
U.S. House of Representatives Committee on Energy & Commerce
Health Subcommittee

"STRENGTHENING MEDICARE FOR SENIORS: UNDERSTANDING THE CHALLENGES OF TRADITIONAL MEDICARE'S BENEFIT DESIGN"

Thursday, April 11, 2013

Respectfully submitted on behalf of

UNITED STEEL, PAPER and FORESTRY, RUBBER, MANUFACTURING, ENERGY, ALLIED INDUSTRIAL and SERVICE WORKERS INTERNATIONAL UNION (USW)

By

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This testimony is submitted on behalf of the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (USW) in connection with the hearing that will be held by the Subcommittee on Health of the House Energy & Commerce Committee on April 11, 2013 on the subject of: "Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare's Benefit Design." The USW represents over 1.2 million active and retired workers in the steel, aluminum, rubber, paper, energy, mining, and health care sectors across the United States. Approximately 65-70% of our retired members receive their primary health care coverage from Medicare. Many of these retirees also receive supplemental health care benefits from their former employers or from Voluntary Employee Beneficiary Associations (VEBAs) that have resulted from court-ordered settlement agreements.

The USW recognizes the need to modernize and rationalize the benefit package provided under Medicare. In particular, it would be important to update and simplify the deductibles, co-insurance and other cost sharing requirements. This could make it easier for retirees to understand these cost sharing requirements. It also could ease the administrative burdens both on Medicare and on employers/VEBAs that provide supplemental coverage.

The USW also strongly supports the addition of catastrophic coverage under Medicare. This has long been a glaring omission in Medicare. Providing protection against

catastrophic medical expenses would help seniors who would otherwise face potentially devastating costs due to serious illnesses.

However, the USW is concerned that the MedPAC proposals for changing the Medicare benefit package would impose substantial additional cost sharing on most seniors. We understand that the MedPAC proposals are intended to maintain in the aggregate the same level of cost sharing as the traditional Medicare benefit package. But in order to pay for the catastrophic protection for a small number of seniors, this means the MedPAC proposals will substantially increase the cost sharing that will have to be borne by most beneficiaries.

The USW opposes this shifting of substantial new costs to most seniors. In 2010, half of all Medicare beneficiaries had annual incomes below $22,000 (200% of the federal poverty level). Medicare households have a lower average budget than the typical household ($30,818 vs. $49,641 respectively), but devote a substantially larger share of their income to medical expenses than does the average household (14.7% vs. 4.9% respectively). Thus, many seniors simply cannot afford the cost sharing implicit in the MedPAC proposals, and would experience significant hardship if they had to pay for these additional costs. Some USW retirees could see their income reduced significantly if they had to pay the cost sharing proposed by MedPAC.

The USW also is skeptical that this increase in cost sharing for most seniors would be effective in restraining the growth in health care spending. To begin with, most retirees

already are paying significant health care costs, and thus have substantial "skin in the game." Furthermore, because most health care expenditures are incurred by a small percentage of the sickest individuals, increasing cost sharing for the majority of persons will not have any impact on the largest component of health care costs. In fact, increasing cost sharing for persons with chronic conditions may be counterproductive, as it may result in higher expenditures for costly hospitalizations and greater use of emergency department services. Instead of trying to control utilization by shifting costs to individuals, it makes more sense to focus on providing incentives for health care providers to deliver care based on quality rather than quantity. The reforms contained in the Affordable Care Act have already started to make progress in this direction. The USW submits that we should be redoubling and accelerating those efforts, rather than shifting more costs to seniors.

The USW is particularly troubled by the part of the MedPAC benefit proposal that would increase the cost sharing for inpatient hospital stays to $750 per stay. This would impose significant hardship on many seniors. And it would have little impact on utilization and health care costs, since providers rather than individuals normally make the decision to admit someone to a hospital.

The USW also opposes the MedPAC proposal to restrict supplemental Medigap coverage for seniors, and similar proposals made by other parties. Sometimes these proposals are designed as an outright prohibition on so-called "first dollar" coverage. Sometimes they are structured as a surcharge on the Part B premiums paid by seniors,

or as a surcharge/excise tax on the supplemental policies themselves. Whatever the structure of the proposals, the net effect is to expose seniors to substantial additional health care costs. In our judgment, this would cause significant hardship for many seniors who simply cannot afford to bear these costs. In addition, as the National Association of Insurance Commissioners recently indicated in a December 19, 2012 letter to Secretary Sebelius, Medigap coverage is not a driver of unnecessary medical care by seniors. Peer reviewed studies do not indicate that increased cost sharing would promote a more "appropriate" use of physicians' services. Instead, this more likely would result in delayed treatments that could increase Medicare program costs.

The USW believes it would be particularly problematic to apply surcharges or benefit prohibitions to supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs. With individual Medigap policies, the individual always has a choice about whether to prospectively purchase the supplemental coverage. But in the case of supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs, the retirees have already given up wages during their active working years based on the promise that they would receive this additional health care protection during their retirement. In our judgment, it would be manifestly unfair to now change the rules and deprive the retirees of the bargain that they negotiated many years ago and that they effectively paid for by foregoing part of their wages. For this reason, if there were going to be some type of surcharge or benefit prohibition, we believe it should be structured as proposed by the Obama administration, so that it

would only apply to individual Medigap policies purchased by beneficiaries who enroll in Medicare after some future date.

In conclusion, the USW appreciates the opportunity to submit our views to the Subcommittee on Health of the Energy & Commerce Committee regarding proposals to change Medicare's traditional benefit design. We look forward to working with Members of the Subcommittee and the entire Congress as you consider these important issues.

UNITED STATES HOUSE of REPRESENTATIVES
COMMITTEE on ENERGY & COMMERCE, SUBCOMMITTEE on HEALTH
HEARING on "STRENGTHENING MEDICARE FOR SENIORS: UNDERSTANDING THE CHALLENGES OF TRADITIONAL MEDICARE'S BENEFIT DESIGN"
April 11, 2013

WRITTEN TESTIMONY SUBMITTED JOINTLY by
CALIFORNIA HEALTH ADVOCATES,
CENTER for MEDICARE ADVOCACY,
and MEDICARE RIGHTS CENTER

Introduction

Mr. Chairman and Members of the Committee:

California Health Advocates, the Center for Medicare Advocacy, Inc., and the Medicare Rights Center are all independent, non-profit organizations with extensive experience representing older adults and people with disabilities who rely on Medicare for basic health and economic security.

Our three organizations also served as consumer representatives to a subgroup of the Senior Issues Task Force (SITF) of the National Association of Insurance Commissioners (NAIC) tasked with reviewing a provision of the Affordable Care Act (ACA) relating to Medigap policies. We offer this testimony through our perspective as beneficiary advocates and members of this deliberative NAIC process that included a range of stakeholders.

In December 2012, as a result of the work of the NAIC subgroup, the NAIC strongly recommended against adding further cost-sharing to Medigap plans in a letter to the U.S. Department of Health and Human Services.[1] In short, the research conducted by the subgroup roundly rejects the basic assumption that limited cost-sharing afforded by Medigap plans leads to overutilization of health care services. The subgroup concluded:

> The proposals [to add cost-sharing to Medigap plans] focus on overutilization by beneficiaries but do not consider the potentially serious and unintended impacts for beneficiaries and the Medicare program. Namely, in response to increased costs, beneficiaries may avoid necessary services in the short-term that may result in worsening health and a need for more intensive care and higher costs to the Medicare program in the long-term. In addition, research indicates that once beneficiaries seek care, doctors and other medical providers, not patients, generally drive the number and types of services delivered to beneficiaries. Further, the proposals do not address the fact that Medicare

[1] National Association of Insurance Commissioners letter to Secretary Sebelius (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.

determines which services are reimbursed and therefore, by law, covered by Medigap insurance policies.[2]

The NAIC determined that increased cost-sharing in Medigap plans was likely to prohibit the use of both necessary and unnecessary health care services. Both the Medicare Payment Advisory Commission (MedPAC) and the Congressional Budget Office (CBO) have acknowledged this same concern in reference to proposals that increase beneficiary out-of-pocket costs.[3] By way of the subgroup's conclusion, the NAIC rebuffed the notion that increased cost-sharing is an appropriate tool to limit unnecessary use of health care services.

Although this NAIC subgroup focused on potential changes to Medigap plans, the research reviewed and the resulting conclusions are applicable to a range of Medicare reform proposals, including the subject of this testimony—Medicare cost sharing and benefit design. Through our work representing people with Medicare, we know that the Medicare program has significant, complicated out-of-pocket costs and can be simplified. With the aim of securing savings, however, restructuring Medicare cost sharing is likely to both unfairly redistribute costs to beneficiaries with limited incomes and limit access to needed health care services by way of self-rationing.

While taking a measured look at the program outside of the context of deficit reduction would be a welcome exercise, we believe that the following Medicare reform proposals would have harmful, unintended consequences for beneficiaries:

- Benefit redesigns that would redistribute cost burdens;
- Prohibiting or taxing Medigap "first-dollar coverage";
- Increasing the share of and/or further means-testing Medicare premiums;
- Raising the age of Medicare eligibility;
- Adding or increasing costs for services, such as home health benefits; and
- Premium support or competitive bidding models that weaken Traditional Medicare.

Each of these proposals might save federal dollars in the short run, but would do so through significant cost-shifting to beneficiaries. At the same time, none of these proposals address the long-term challenge of systemic health care inflation that threatens our nation's ability to provide affordable health care, both in public and private markets.

Our organizations recognize the need to bring down the nation's deficit and reduce health care spending system-wide. We support Medicare savings mechanisms that eliminate wasteful

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[2] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

[3] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf; Congressional Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf.

spending and build on the efficiencies of the ACA. At a time when Medicare spending is growing at historically low rates, and innovations through the ACA hold considerable promise of continuing to keep costs down, we oppose implementing unwise policies that seek federal savings by way of cost-shifting on the backs of Medicare beneficiaries.

Our testimony focuses on how the most discussed proposals to redistribute Medicare cost sharing would impact the lives of people with Medicare. Under the proposed concepts, too many would lose access to affordable coverage, and too many would be discouraged from seeking needed health care services. In short, these proposals threaten the health and economic security of people with Medicare.

Current Expenses and Coverage for Medicare Beneficiaries

Before considering proposals that would alter what Medicare beneficiaries pay for their health care, it is necessary to understand the current fiscal challenges faced by this population. The vast majority of Medicare beneficiaries have low or moderate incomes. In 2012, half of all Medicare beneficiaries had annual incomes below $22,500, or below 200 percent of the federal poverty level (FPL).[4] Half of beneficiaries had just $53,000 in personal savings.[5] One-third of Medicare beneficiaries have annual incomes below $16,755—150% of the FPL for a single person.[6]

Medicare beneficiaries pay relatively more than other groups for their health care. Medicare households have a lower average budget than the average household (about $30,800 vs. $49,600 respectively) but devote a substantially larger share of their income to medical expenses than does the average household (15% vs. 5% respectively). Two-thirds of the medical spending by Medicare households goes to premiums for Part B, Medicare Advantage, Part D, and/or supplemental coverage.[7]

Medicare beneficiaries also tend to have greater health needs than other groups. Nearly half (46 percent) of older adults covered by Medicare have three or more chronic conditions, and nearly one-fourth (23%) are in fair or poor health.[8] Typical out-of-pocket health spending for someone in fair or poor health without any supplemental benefits is about $4,500 per year.[9]

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[4] Kaiser Family Foundation, "Policy Options to Sustain Medicare for the Future" (January 2013), available at: http://www.kff.org/medicare/upload/8402.pdf

[5] Kaiser Family Foundation, "Projecting Income and Assets: What Might the Future Hold for the Next Generation of Medicare Beneficiaries?" (June 2011), available at: http://www.kff.org/medicare/upload/8172.pdf.

[6] General Accounting Office (GAO), "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment" (September 2012), available at: http://www.gao.gov/assets/650/648370.pdf .

[7] Kaiser Family Foundation, "Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare Households. An Updated Analysis of Health Care Spending as a Share of Total Household Spending" (March 2012), available at http://www.kff.org/medicare/upload/8171-02.pdf.

[8] Kaiser Family Foundation, "Key Issues in Understanding the Economic and Health Security of Current and Future Generations of Seniors" (March 2012), available at: http://www.kff.org/medicare/upload/8289.pdf.

[9] MedPAC, "A Data Book: Health Care Spending and the Medicare Program" charts 5-6 (June 2012), available at: http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf.

Because the current Medicare benefit is not overly generous and requires considerable out-of-pocket costs, approximately 90% of Medicare beneficiaries have some type of coverage that supplements Medicare. Some have retiree benefits through former employment (30%), Medicare Advantage plans (29%), Medicaid (14%) and Medigap (18%), and others who have only Medicare (8%) are also entitled to benefits through the Veteran's Administration.[10] Many of these supplemental types of insurance, in effect, limit out-of-pocket expenses. Even with these supplemental coverage options, people with Medicare lack coverage for particular services, including most long-term care services and supports and dental care.

Most Medicare beneficiaries cannot absorb more costs without facing significant hardship. To borrow a crude metaphor, Medicare beneficiaries already have too much "skin in the game," and as a group, are very aware of the high cost of health care services based on the bills they receive and Medicare's summary notice of payment.

Proposals to Redesign Medicare's Benefit Structure

Over the last few years, there have been several proposals offered by various lawmakers, commissions and other entities that seek to alter Medicare's benefit structure. Although they have been offered within the context of debt and deficit reduction, some proposals claim to have the plight of Medicare beneficiaries firmly in mind. These proposals appear benign on their face in that they simplify Medicare's structure; however, upon closer scrutiny, they merit significant concern because they increase beneficiaries' costs and thereby limit their access to care.

In its June 2012 Report to Congress, MedPAC made recommendations to alter the Traditional Medicare benefit package, including redistributing cost-sharing through the use of tiered copayments, coinsurance and a combined deductible for Medicare Parts A and B, along with an out-of-pocket maximum for beneficiaries in Traditional Medicare. For illustrative purposes, not as a recommendation, MedPAC modeled a $500 combined deductible, varying copayments and a $5,000 spending limit, along with a 20% surcharge on supplemental plan premiums.[11]

Various other proposals to redesign Medicare's benefit structure contain similar elements, including: creating a single, combined deductible for Parts A and B (ranging from $500 to $550); a uniform 20% coinsurance rate; an out-of-pocket cap on beneficiary expenses (ranging from $5,500 to $7,500); and various piecemeal proposals, such as introducing home health copayments.[12]

Often proposals to redesign Medicare's benefits are coupled with proposals to restrict Medigap "first-dollar coverage." Medicare supplemental insurance policies, also known as Medigap

[10] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), "Variations and Trends in Medigap Premiums" (December 2011), available at: http://aspe.hhs.gov/health/reports/2011/medigappremiums/index.pdf.

[11] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

[12] Kaiser Family Foundation, "Policy Options to Sustain Medicare's Future" (January 2013), available at: http://www.kff.org/medicare/upload/8402.pdf.

plans, are individual standardized insurance policies designed to fill some of the coverage gaps of Traditional Medicare. In exchange for a monthly premium, these policies offer financial security and protection against high and sporadic out-of-pocket costs for 9.3 million Medicare beneficiaries.[13] Policies that provide coverage for Medicare cost-sharing once Medicare has paid its portion are sometimes referred to as providing "first-dollar coverage."

Economic and Health Risks Posed by Redistributing Medicare Cost Sharing

Proposed Changes to Medicare Cost Sharing Shifts Costs to Beneficiaries

At first glance, combining the Part A and B deductibles and adding a catastrophic cap on out-of-pocket expenses seems like a credible concept. While details are lacking in most proposals, the broad outlines of those currently under discussion would increase costs for most people, and significantly so for those who can least afford it. Some of these proposals purport to operate under the premise of "budget neutrality," or claim "no change in beneficiaries' aggregate cost-sharing liability."[14] Yet, changing cost-sharing structures in the manner proposed redistributes the burden of health care costs onto the most vulnerable, including those with low- and moderate-incomes and those with persistent and chronic health needs.[15]

In particular, individuals who are "near poor"—beneficiaries with incomes too high to qualify for low-income programs but still living on limited incomes—are most at risk. Additional upfront costs of a higher deductible for Part B services as well as any higher ongoing costs, such as new and/or higher coinsurance amounts, will make necessary care unaffordable and lead many people to forego critical care.

In 2011, the Kaiser Family Foundation issued a report analyzing the impact of a benefit redesign proposal modeled on one offered by Erskine Bowles and Alan Simpson (Bowles-Simpson), co-chairs of the National Commission on Fiscal Responsibility and Reform (a unified Part A and B deductible of $550, 20 percent coinsurance on most Medicare-covered services, and a $5,500 annual limit on out-of-pocket spending). The study shows that 71% of beneficiaries in Traditional Medicare would have higher out-of-pocket spending—even with a spending cap—and 5 percent would have lower out-of-pocket spending. Five million beneficiaries among this group would experience increased costs greater than $250 annually, with a total average increase of $660 per year.[16]

Under MedPAC's analysis of their own illustrative benefit redesign package, at least 20% of beneficiaries would pay an additional $250-$999 per year; their proposal coupled with a

[13] Kaiser Family Foundation, "Medigap: Spotlight on Enrollment, Premiums and Recent Trends" (February 2013), available at: http://www.kff.org/medicare/upload/8412.pdf.

[14] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

[15] Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at: http://www.kff.org/medicare/upload/8256.pdf.

[16] Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at: http://www.kff.org/medicare/upload/8256.pdf.

surcharge on Medigap plans would lead to 70% paying additional costs within this range.[17] To cite an individual example, under the MedPAC and Bowles-Simpson proposals, a person with Medigap Plan F paying an average annual premium of about $2,050 today would pay more than twice as much in out-of pocket costs, while couples would pay two and a half times more.[18]

Cost-Shifting to Beneficiaries Limits Access to Necessary Care

While increased cost-sharing poses significant financial risks for beneficiaries, particularly for those living on low- and moderate-incomes, it is also shown to limit access to necessary health care services. This was a primary finding of the NAIC subgroup convened to explore adding cost-sharing to specific Medigap plans on which our organizations served.

Pursuant to the ACA, the NAIC was directed to "review and revise the standards for benefits in Medigap Plan C and Plan F" and to update those standards to include cost-sharing, if practicable, so as to "encourage the use of appropriate physicians' services..."[19] Toward this end, the NAIC convened the Medigap PPACA (B) Subgroup that included state insurance regulators, insurers and trade associations, consumer advocates and other Medicare experts. This subgroup spent almost two years reviewing available literature on cost-sharing and patient behaviors.[20] In addition, mid-way through its deliberations, the NAIC subgroup issued a discussion paper on more expansive proposals to diminish Medigap coverage and increase Medicare cost-sharing.[21]

Proposed changes to Medigap made by some policymakers aim to either: 1) add a surcharge or tax to policies that offer first-dollar coverage, or 2) impose a deductible and limited coverage of additional cost-sharing, essentially prohibiting first-dollar coverage outright. Proposals to redistribute the burden of Medicare cost sharing, such as the one offered by MedPAC and Bowles-Simpson, often couple combining the Medicare Part A and B deductibles with restrictions on Medigap benefits or by increasing the cost of owning a Medigap plan. Some proposals would entail applying restrictions and/or increased costs on both current and future beneficiaries raising legal issues for insurance policies that are guaranteed renewable.

The subgroup's research demonstrates that added cost-sharing has dubious utility in holding down health care spending and can actually lead to increased total spending on health care when

[17] MedPAC Presentation, "Reforming Medicare's Benefit Design" (March 2012), slide 10, available at: http://www.medpac.gov/transcripts/benefit%20design%20mar2012%20public.pdf .

[18] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), "Variations and Trends in Medigap Premiums" (December 2011), available at: http://aspe.hhs.gov/health/reports/2011/medigappremiums/index.pdf.

[19] Patient Protection and Affordable Care Act, §3210.

[20] National Association of Insurance Commissioners, "Medigap PPACA (B) Subgroup" webpage, available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; See under heading "Cost-sharing Research and Literature" for summary of much of this literature (as of June 2011) available at: http://www.naic.org/documents/committees_b_senior_issues_110628_summary_dist_research.pdf.

[21] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

people forego medically necessary services. For example, a major Harvard School of Public Health review of the research on cost-sharing made several conclusions about its utility in controlling health care costs, including: "We do not know if increased patient cost-sharing would reduce the growth in total national health care spending;" "Increased cost-sharing disproportionately shifts financial risk to the very sick;" "Low-income older adults with chronic conditions are at increased risk for poor health outcomes due to increased cost-sharing."[22]

In 2008, the CBO similarly determined that a proposal to restrict Medigap coverage of Medicare cost-sharing would lead beneficiaries to face "uncertainty about their out-of-pocket costs." Given this, the CBO further acknowledged that the corresponding "...decline in the use of services by Medigap policyholders (which would generate the federal savings under this option) might lead beneficiaries to forego needed health services and so might adversely affect their health."[23]

Due in large part to these findings, in a letter to Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services, the NAIC concluded, "We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost-sharing designed to encourage the use of appropriate physicians' services. Therefore, our recommendation is that no nominal cost-sharing be introduced to Plans C and F."[24]

In addition, the NAIC letter to Secretary Sebelius stated, "We do not agree with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries. As you are aware, Medigap plans pay benefits only after Medicare has determined that the services are medically necessary and has paid benefits. Medigap cannot alter Medicare's coverage determination and the assertion that Medigap coverage causes overuse of Medicare services fails to recognize that Medigap coverage is secondary and that only Medicare determines the necessity and appropriateness of medical care utilization and services."

Our organizations strongly support the NAIC's determination. The conclusions drawn by this subgroup are applicable not only to Medigap reform proposals, but also to proposals that would increase beneficiary out-of-pocket costs, including the frameworks noted above that would redistribute the burden of Medicare cost sharing.

Low-Income Protections

Medicare's low-income protections, including the Low-Income Subsidy of Medicare Part D (Extra Help) and the Medicare Savings Programs (MSPs), are woefully inadequate. In their current form, these benefits do not fully extend to those who cannot afford to pay for necessary

[22] Katherine Swartz, "Cost-Sharing: Effects on Spending and Outcomes" (December 2010), Robert Wood Johnson Foundation Research Synthesis Report No. 20, available at: http://www.naic.org/documents/committees_b_senior_issues_110628_rwjf_brief.pdf

[23] Congressional Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf.

[24] National Association of Insurance Commissioners letter to Secretary Sebelius (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.

health care services. We believe that these protections should be strengthened, regardless of other reform proposals that might be implemented. Any attempt to restructure Medicare cost sharing must begin with the modernization of these critical low-income protections.

Congress should take steps to strengthen these subsidy programs for low-income Medicare beneficiaries. Currently, full Part A, B and D subsidy protection is provided only for those with incomes up to 100% of FPL, about $11,500 in 2013. In order to assist more people who truly cannot afford to pay for their health care, the income thresholds for full subsidy protection should be increased to at least 200% of FPL. Similarly, the asset tests for these programs should be eliminated, similar to the elimination of asset testing for Medicaid expansion under the ACA. In addition, individuals enrolled in an MSP are automatically enrolled in LIS without further action on their part, but the reverse is not true. In order to fix this problem, eligibility requirements for MSP and LIS should be fully aligned to allow for cross-deeming. If program requirements were fully aligned, enrollment in one could serve as enrollment in both.

Taking these steps would help reduce the current cost burdens on many low-income Medicare beneficiaries. Any discussion of redistributing cost sharing in Medicare, even one that is budget neutral, must include proposals to strengthen programs for those with low incomes.

Conclusion

We remain deeply concerned about the effects of further cost-shifting onto people with Medicare, and we believe these proposals pose substantial risks to the health and economic security of Medicare beneficiaries, namely those with low- and modest-incomes and people with significant health needs. We acknowledge, however, that we must find savings in the Medicare program to sustain this guaranteed health benefit for today's generation and future generations.

Towards this end, we support prudent cost containment designed to solve the true threat to our nation's fiscal health: rising health care costs system-wide. To realize this goal, we endorse cost-saving solutions that eliminate wasteful spending and promote the delivery of high value care—meaning better quality at a lower price. Proposals our organizations support include:

Reduction of wasteful spending on drugs, medical equipment and private health plans: Significant cost savings can be achieved by allowing the Medicare program to secure lower prices on pharmaceutical drugs. Congress should expand the tools available to the federal government to achieve this end, including restoring Medicare drug rebates, allowing the federal government to directly negotiate with pharmaceutical companies and introducing a public drug benefit in Medicare.

In addition, Congress should expand the cost savings already achieved by the Centers for Medicare & Medicaid Services (CMS) through the successful competitive bidding demonstration for durable medical equipment. Expansion of the competitive bidding on a national scale should be accelerated and extended to other types of medical equipment, such as lab tests and advanced imaging services.

The ACA took major strides to reduce sizable overpayments to Medicare Advantage. More should be done to equalize payments between Traditional Medicare and private Medicare plans. Private plans should be reimbursed no more than Traditional Medicare.

Advance Medicare delivery system reforms made possible by health reform:
The ACA includes many opportunities to test delivery system reforms designed to enhance health care quality while simultaneously driving down the cost of care. These reforms are meant to improve care quality by promoting better coordination among providers, patients and caregivers to prevent harmful drug interactions, unnecessary hospitalizations and more.

Congress should maximize the Administration's authority to test these reforms in a timely manner. At the same time, Congress should avoid dramatically altering Medicare benefits, so as to allow time for these advancements to yield results, meaning both improved care coordination and better cost-effectiveness.

We look forward to working with the Committee and members of Congress to examine additional cost-saving options in the Medicare program that simultaneously address the systemic issue of rising health care costs that concern not only Medicare, but also to the private health insurance market. We implore you to reject proposals that fail to address this systemic issue and instead achieve only short-term savings by shifting costs to people with Medicare. As such, we ask that you carefully weigh the significant risks posed to Medicare beneficiaries by the proposals discussed above and we urge you to steer clear of these models.

We appreciate this opportunity to submit these comments.

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April 11, 2013

For the Record
House Energy & Commerce Committee, Health Subcommittee

Testimony by Josh Nassar, Legislative Director, International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW)

This testimony is submitted on behalf of the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW) in connection with the hearing that will be held by the Subcommittee on Health of the House Energy & Committee on April 11, 2013 on the subject of: "Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare's Benefit Design." The UAW represents over 1.2 million active and retired workers in the auto, aerospace, education and public sectors across the United States. About two thirds of our retired members receive their primary health care coverage from Medicare. Many of these retirees also receive supplemental health care benefits from their former employers or from Voluntary Employee Beneficiary Associations (VEBAs) that have resulted from court-ordered settlement agreements.

The UAW recognizes the need to modernize and rationalize the benefit package provided under Medicare. In particular, it would be important to update and simplify the deductibles, co-insurance and other cost sharing requirements. This could make it easier for retirees to understand these cost sharing requirements. It also could ease the administrative burdens both on Medicare and on employers/VEBAs that provide supplemental coverage.

The UAW also strongly supports the addition of catastrophic coverage under Medicare. This has long been a glaring omission in Medicare. Providing protection against catastrophic medical expenses would help seniors who would otherwise face potentially devastating costs due to serious illnesses.

However, the UAW is concerned that the MedPAC proposals for changing the Medicare benefit package would impose substantial additional cost sharing on most seniors. We understand that the MedPAC proposals are intended to maintain **in the aggregate** the same level of cost sharing as the traditional Medicare benefit package. But in order to pay for the catastrophic protection for a small number of seniors, this means the MedPAC proposals will substantially increase the cost sharing that will have to be borne by most beneficiaries.

The UAW opposes this shifting of substantial new costs to most seniors. In 2010, half of all Medicare beneficiaries had annual incomes below $22,000 (200% of the federal poverty level). Medicare households have a lower average budget than the typical household ($30,818 vs. $49,641 respectively), but devote a substantially larger share of their income to medical expenses than does the average household (14.7% vs. 4.9%

respectively). Thus, many seniors simply cannot afford the cost sharing implicit in the MedPAC proposals, and would experience significant hardship if they had to pay for these additional costs. Some UAW retirees could see their income reduced by up to a quarter if they had to pay the cost sharing proposed by MedPAC.

The UAW also is skeptical that this increase in cost sharing for most seniors would be effective in restraining the growth in health care spending. To begin with, most retirees already are paying significant health care costs, and thus have substantial "skin in the game." Furthermore, because most health care expenditures are incurred by a small percentage of the sickest individuals, increasing cost sharing for the majority of persons will not have any impact on the largest component of health care costs. In fact, increasing cost sharing for persons with chronic conditions may be counterproductive, as some seniors would delay getting needed treatment and as a result, end up incurring higher expenditures for costly hospitalizations and greater use of emergency department services for issues that could have been dealt with in their doctor's office. Instead of trying to control utilization by shifting costs to individuals, it makes more sense to focus on providing incentives for health care providers to deliver care based on quality rather than quantity. The reforms contained in the Affordable Care Act have already started to make progress in this direction. The UAW submits that we should be redoubling and accelerating those efforts, rather than shifting more costs to seniors.

The UAW is particularly troubled by the part of the MedPAC benefit proposal that would increase the cost sharing for inpatient hospital stays to $750 per stay. This would impose significant hardship on many seniors. And it would have little impact on utilization and health care costs, since providers rather than individuals normally make the decision to admit someone to a hospital.

The UAW also opposes the MedPAC proposal to restrict supplemental "Medigap" coverage for seniors, and similar proposals made by other parties. Sometimes these proposals are designed as an outright prohibition on so-called "first dollar" coverage. Sometimes they are structured as a surcharge on the Part B premiums paid by seniors, or as a surcharge/excise tax on the supplemental policies themselves. Whatever the structure of the proposals, the net effect is to expose seniors to substantial additional health care costs. In our judgment, this would cause significant hardship for many seniors who simply cannot afford to bear these costs. In addition, as the National Association of Insurance Commissioners recently indicated in a December 19, 2012 letter to Secretary Sebelius, Medigap coverage is not a driver of unnecessary medical care by seniors. Peer reviewed studies do not indicate that increased cost sharing would promote a more "appropriate" use of physicians' services. Instead, this more likely would result in delayed treatments that could increase Medicare program costs.

The UAW believes it would be particularly problematic to apply surcharges or benefit prohibitions to supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs. With individual Medigap policies, the individual always has a choice about whether to prospectively purchase the supplemental coverage. But in the case of supplemental health care benefits provided to retirees by employers, Taft

Hartley plans or VEBAs, the retirees have already given up wages during their active working years based on the promise that they would receive this additional health care protection during their retirement. In our judgment, it would be manifestly unfair to now change the rules and deprive the retirees of the bargain that they negotiated many years ago and that they effectively paid for by foregoing part of their wages. For this reason, if there were going to be some type of surcharge or benefit prohibition, we believe it should be structured as proposed by the Obama administration, so that it would only apply to individual Medigap policies purchased by beneficiaries who enroll in Medicare after some future date.

In conclusion, the UAW appreciates the opportunity to submit our views to the Subcommittee on Health of the Energy and Commerce Committee regarding proposals to change Medicare's traditional benefit design. We look forward to working with Members of the Subcommittee and the entire Congress as you consider these important issues.

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STATEMENT SUBMITTED BY

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TO THE

HOUSE ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH

APRIL 11, 2013

The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the House Energy and Commerce Subcommittee on Health examines the challenges of traditional Medicare's benefit design, NAHC appreciates this opportunity to provide our views on proposals to restructure cost sharing within Medicare. Some policymakers have suggested adding copayments for Medicare home health and hospice services as a means of both reducing the deficit and preventing overutilization of home health and hospice services.

Congress eliminated the home health copayment in 1972 for the very reasons it should not be resurrected now. The home health copayment in the 1960s and 1970s deterred Medicare beneficiaries from accessing home health care and instead created an incentive for more expensive institutional care. Reinstating the home health copay today would undo the progress made in efforts to reduce unnecessary hospitalizations and nursing home stays.

Moreover, home health services and hospice care already have the highest cost-sharing in Medicare. On a daily basis, millions of spouses, family, friends, and community groups

contribute the equivalent of billions of dollars worth of care and support to keep their loved ones at home. Further, care in the home means that the Medicare beneficiary provides all the financial support in terms of room and board that are otherwise paid for by Medicare and Medicaid in an institutional setting.

Numerous studies have concluded that a copay can discourage use of necessary and beneficial care, resulting in the deterioration of a patient's condition and ultimately leading to higher costs for the Medicare program through acute care interventions in higher cost settings. With hospice patients, barriers to comfort at the end of life add both avoidable costs and avoidable pain.

We respectfully submit that Congress should oppose any copay proposal for Medicare home health and hospice services.

HOME HEALTH CARE

Proposals to impose a home health copay should be rejected for the following reasons:

- **Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.** The Urban Institute's Health Policy Center found that home health copays "...would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays."[i] Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.[ii] The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, "may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long run."[iii] Studies have shown that Medicaid copays can backfire with beneficiaries avoiding care leading to higher Medicaid overall costs.[iv] The Veterans Administration recently eliminated copays for in-home video telehealth care to prevent avoidable hospitalizations of veterans.[v] According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by $6-13 billion over ten years.[vi]

- **The burden of a home health copayment would disproportionately impact the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.[vii] Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.[viii] The Commonwealth Fund cautioned that "cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs."[ix]

- **Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries—about 25 million seniors and people with disabilities—lived on incomes below $22,000, just under 200 percent of the federal poverty level.[x] Medicare households already spend on average 15 percent of their income on health care costs, three times as much as the non-Medicare population.[xi]

- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100 percent of poverty ($11,412 for singles, $15,372 for couples) and non-housing assets below just $6,940 for singles and $10,410 for couples. In sharp contrast, eligibility for cost sharing assistance for individuals under age 65 is set at 138 percent of poverty, with no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third actually have it.[xii]

- **Individuals receiving home care and their families already contribute to the cost of their home care.** With hospital and nursing home care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out-of-pocket by individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated $450 billion a year in unpaid care to their loved ones,[xiii] and too frequently having to cut their work hours or quit their jobs.

- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not "order" home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary, that beneficiaries are homebound and meet other stringent standards. There is no evidence of systemic overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.[xiv]

- **Home health copayments would shift costs to the states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by the Medicare Payment Advisory Commission (MedPAC)) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.

- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay and only 17 percent of Medicare beneficiaries have Medigap coverage. For the 34 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree

coverage.[xv] Likewise, the 25 percent of beneficiaries enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.

- **Copayments would impose costly administrative burdens and increase Medicare costs.** Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care. Home health agencies cannot absorb these costs as nearly 50 percent of home health agencies are projected to be paid less than their costs by Medicare. Overall home health agency margins from a combination of Medicare, Medicaid, Medicare Advantage and other payment sources average less than zero.[xvi]

HOSPICE

The Medicare hospice benefit was created under the Tax Equity and Fiscal Responsibility Act of 1982 to expand the availability of compassionate and supportive care to Medicare's many beneficiaries suffering from terminal illness at the end of life. Eligibility for hospice is based upon a physician's certification that the patient has a terminal illness with a life expectancy of six months or less if the illness runs its normal course. When a patient elects hospice under Medicare, he or she agrees to forgo other "curative" treatment for the terminal illness. While the cost of most hospice care is covered by Medicare, the patient may be responsible for copayments related to drugs for symptom control or management and facility-based respite care. The patient is also responsible for copayments related to any regular Medicare services unrelated to the terminal diagnosis.

Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit. The average Medicare hospice beneficiary receives care at a cost of approximately $11,500. With the cost sharing changes that have been proposed, a 20 percent copay would impose a charge of approximately $2,300 on terminally ill individuals in the last days of their lives. Given the requirement that a patient be determined to be terminally ill with a plan of care developed by an interdisciplinary team, there is no need for an additional check on utilization of care. Implementing a Medicare copayment for these services would cause many terminally ill patients to second guess their physician and care team in the last days of their life.

Historically, copayments have been imposed on health care services to reduce overutilization of services. While use of hospice services has grown significantly through the years, many Medicare beneficiaries are referred to hospice too late to reap its full benefit, and many more lack sufficient knowledge or understanding of hospice to consider it a viable option at the end of their lives. This is particularly the case for minority and low-income Medicare populations – who are the least likely to be able to afford additional cost-sharing burdens.

Beneficiaries who elect Medicare hospice services must agree to forego curative care for their terminal illness. Given that many "curative" interventions for terminal illnesses can involve administration of costly new medications and treatments, it is not surprising that numerous

studies have documented that appropriate use of hospice services can actually reduce overall Medicare outlays while at the same time extending length and quality of life for enrolled beneficiaries.[xvii]

While valid concerns have been raised about the length of time some Medicare beneficiaries are on hospice service, the median length of stay under the hospice benefit is about 17 days, and 95 percent of hospice care is provided in the home. Congress has already addressed concerns relative to extended length of stays in hospice care by requiring a face-to-face encounter prior to the start of the third and later benefit periods. Through that change, ineligible individuals are screened out and improper Medicare payments are avoided. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate and desirable use of the hospice benefit, Congress and other policymakers should explore additional ways to ensure that hospice services are being ordered for patients that are truly eligible, such as through physician education.

PROPOSALS TO ADDRESS CONCERNS ABOUT PROGRAM INTEGRITY

Rather than applying a copay to address concerns that have been raised about possible overutilization and wasteful spending on home health services in certain parts of the country, NAHC suggests targeted approaches that do not restrict access to care and penalize Medicare beneficiaries and ethical home health providers. It is essential that Medicare operate with integrity and compliance as millions of Americans depend on this program every day to meet their health care needs. Eliminating wasteful spending should be the highest priority in that regard. For too long, honest and compliant providers and beneficiaries have had to pay through increased costs, reduced benefits, and payment rate reductions for the misdeeds and criminal conduct of bad actors that seek to take advantage of systemic weaknesses in Medicare. NAHC fully supports efforts to address these weaknesses with constructive and well-focused action. The home care and hospice community recognizes that they must be responsible stewards of the limited resources available to Medicare. We also recognize that it is a privilege to be a participating provider in these programs and that we can be effective partners with government in combatting fraud, waste, and abuse.

In recent years, new policies and administrative practices have been instituted to address care overutilization concerns. For example, Medicare has added oversight and "real-time" predictive modeling to target aberrant providers, using its contractors such as the Zone Program Integrity Contractors (ZPICs) and Recovery Audit Contractors (RACs) in addition to its longtime claims reviews by the everyday Medicare Administrative Contractors (MACs). Also, an industry-developed restriction on home health outlier episodes in home health services eliminated abusive claims, reducing unnecessary Medicare spending by $1 billion in in its first year, 2010.

Other measures have been instituted by Medicare, including more stringent provider participation standards, a periodic professional therapist assessment requirement prior to continued care, and a physician face-to-face encounter requirement to initiate covered home health services. These and other changes have led to an actual reduction in Medicare home health spending, a phenomenon unique in the Medicare program in recent years. In fact, home health

spending and utilization is less today than in 1997. In today's dollars, Medicare home health spending is about 40 percent lower than in 1997 while all other sectors have significantly increased. Still, home care and hospice wish to lead rather than follow in program integrity innovations.

In that spirit, we offer ten recommendations that we believe can further reduce wasteful spending and prevent fraudulent conduct. These recommendations include a combination of steps that are directed to the primary reason that concerns about fraud and abuse exist – the system permits bad actors and parties without adequate competencies to enter Medicare program. In addition, these recommendations also offer a series of improvements focused on existing providers of care designed to ensure ongoing and continuous compliance. These recommendations are designed to address both deliberate fraud and abuse and harm caused by ignorance or lack of competence.

1) **Implement a targeted, temporary moratorium on new home health agencies.** CMS has expressed growing concerns about the entry of fraudulent providers into the Medicare program. With respect to Medicare home health services, there is strong evidence that much of the fraud, waste, and abuse stems from the entry of new providers in areas of the country already saturated with existing home health agencies. CMS has not exercised its authority to impose targeted moratoria on new home health agencies in spite of the evidence that certain areas of the country already have too many providers. Congress should mandate the implementation of a temporary, targeted moratorium on new home health agencies in geographic areas where there is a highly disproportionate number of providers relative to the number of beneficiaries in an area. It should apply certain standard exceptions to a moratorium such as where the state has a Certificate of Need program and the state determines that there is a need for additional providers; the provider is establishing a branch office or multiple locations within its geographic service area; or the provider has submitted the appropriate CMS Form 855A prior to the public notice of any moratorium.

2) **Require credentialing of home health agency executives.** Strengthen Medicare program participation standards to include experience, credentialing and competency testing of home health agency owners, managers, and personnel responsible for maintaining compliance with Medicare standards. Competency credentialing should be made part of the Medicare provider screening model and applied to both new and existing providers of home health services. The credentialing should include minimum training and competency testing of owners and managers in all areas of Medicare/Medicaid operations including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions.

3) **Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care.** The current home health prospective payment system (HHPPS) includes higher reimbursement for episodes with more therapy visits. Reimbursement for episodes increases incrementally as the number of therapy visits increase. Any episodic prospective payment system that relies on the volume of services to determine payment amounts raises the risk of service overutilization. The current case mix adjustment model for home health services payment should be modified to eliminate

the use of a payment modifier based on the volume of therapy visits. Sufficient Medicare resources should be invested to expedite refinements to the Medicare home health payment system so that the provision of services is better aligned with patient characteristics and costs of providing care, rather than the number of visits provided per episode for any service.

4) **Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan.** Congress should require expedited implementation of corporate compliance plans by home health agencies to ensure adherence to all federal and state laws with proper funding support. Compliance program implementation, development and maintenance should include the following: corporate compliance plan frameworks based on the elements put forth in the Sentencing Guidelines; tailored to address specific risk areas; periodically re-evaluated; taken into consideration by CMS when making payment rate changes; outreach and education activities by CMS for providers to implement a compliance plan; and 12 months to fully implement a compliance plan following the publication of any rule.

5) **Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment, prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors.** CMS has implemented provider screening, including fingerprinting. However, participation standards should be established to further reduce the risk that unscrupulous, as well as inexperienced providers continue to manage to obtain Medicare participation agreements on the front-end. Congress should increase the initial capitalization requirements to the equivalent of one year operation; establish a "probationary enrollment" for new providers during which all new home health agencies are subject to 100 percent medical review for at least 30 days, followed by a minimum of 10 percent medical review for the first year in the program; establish a mandatory in-service training requirement during the probationary period on regulations and policies including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions; conduct State Agency full resurveys of all new home health agencies at 6 months of operation; and require training for all State surveyors in coverage standards, with reporting of questionable billing practices to the MACs.

6) **Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries.** Congress should establish a Medicare Home Health Benefit Program Integrity Advisory Council appointed by the Secretary of HHS with representation from Medicare beneficiaries, home health agencies, organizations representing beneficiaries and home health agencies, the Centers for Medicare and Medicaid Services, the Office of Inspector General of the US Department of Health and Human Services, and the US Department of Justice. Its purpose is to: evaluate and assess existing compliance oversight systems and system performance within the Department of Health and Human Services and its contractors regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; recommend

compliance oversight system improvements that should be developed and implemented by the Secretary; evaluate and assess existing compliance oversight systems within home health agencies and system performance regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; and recommend compliance oversight system improvements that should be developed and implemented by home health agencies.

7) **Require criminal background checks on home health agency owners, significant financial investors, and management.** A key to program integrity in Medicare and Medicaid home care starts at the top. Congress should require criminal background check requirements on all individuals seeking to open and operate an agency and those who finance the creation of the agency. Medicare participation should be denied to any prospective owner where that owner or party providing the financial capital to open the home health agency has a criminal background that involves patient abuse, neglect, or misappropriation of patient property or involves a financial related crime that indicates a risk to the integrity of Medicare.

8) **Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight.** Government enforcement entities do not have sufficient resources to address all concerns regarding fraud, waste and abuse in federal health care programs. Congress should authorize the establishment of private enforcement and sanction power by an industry-sponsored entity as an adjunct and complement to existing federal enforcement powers. The entity would be industry-financed, subject to operational standards developed by HHS, and open and transparent in a manner equivalent to a federal agency. The private enforcement entities would be authorized to impose monetary and operational sanctions on Medicare/Medicaid participating providers of care, including suspension of the provider participation agreement, institution of corporate integrity agreements, and fines for noncompliance. The entities would have audit authority in order to engage in an investigation of alleged noncompliance.

9) **Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of program standards.** The Medicare home health benefit is governed by complex laws and regulations that lead to misinterpretation of coverage, payment, and program integrity rules. In addition, providers frequently receive conflicting information from various sources involved in enforcing program integrity. Congress should ensure that education and training of the Medicare program is a joint effort among home health providers, regulators, state surveyors, and Medicare contractors by taking the following steps: develop education sessions to be conducted nationally and open to all stakeholders; provide educational resources that are accessible and that provide clear interpretations to CMS regulations and policies; require greater transparency on instructions provided to the Medicare contractors on payment, coverage, and program integrity policies; and abandon use of local coverage decisions (LCD) and require that only national coverage decisions be used for coverage and payment guidelines.

10) **Utilize targeted provider edits for application of claims reviews and oversight activities. In Medicare home health services, the variation in utilization warrants careful attention.** While the benefit may offer a wide range of services to be covered and permit coverage of extended periods of care, extreme instances of high levels of utilization should be subject to increased scrutiny. For example, MedPAC has highlighted the 25 counties with the highest level of utilization. In some instances, providers have twice the national average in the number of episodes per beneficiary per year. Although beneficiaries can qualify for an unlimited number of 60 day episodes in a calendar year, the extraordinary difference between national average utilization and these providers should trigger claims reviews, including a prepayment authorization process. Such an episode volume process edit will require providers to prove that their claims meet coverage standards.

In relationship to hospice care, NAHC's affiliated Hospice Association of America (HAA) has developed a similar list of program integrity recommendations that we would be happy to supply to the Committee.

MEDICARE INNOVATIONS TO PROMOTE HIGH QUALITY CARE AT LOWER COST

NAHC suggests the following reforms in the Medicare benefit structure that would incentivize high quality care while saving Medicare dollars:

1) **Ensure home care and hospice participation in transitions in care, accountable care organizations, chronic care management, health information exchanges, and other health care delivery reforms.** Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS's implementation of the health care delivery reform provisions in the Patient Protection and Affordable Care Act (PPACA) to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

2) **Allow nurse practitioners and physician assistants to sign home health plans of care.** Congress should enact the bipartisan Home Health Care Planning Improvement Act that would allow Nurse Practitioners (NP) and Physician Assistants (PA) to certify and make changes to home health plans of treatment. NPs and PAs are playing an increasing role in the delivery of our nation's health care, especially in rural and other underserved areas. Medicare reimburses NPs and PAs for providing physician services to Medicare patients. NPs and PAs can certify Medicare eligibility for skilled nursing facility services, but not more cost effective care in the home.

3) **Recognize telehomecare interactions as bona fide Medicare services.** Congress should: 1) establish telehomecare services as distinct benefits within the scope of Medicare coverage guided by the concepts embodied in the Fostering Independence Through Technology (FITT) Act, which should include all present forms of telehealth services and allow for sufficient flexibility to include emerging technologies; 2) clarify that telehomecare qualifies as a covered service under the Medicare home health services and hospice benefits and provide appropriate reimbursement for technology costs; 3) expand the list of authorized originating sites for telehealth services by physicians under section §1834(m)(3)(C) to include an individual's home; and 4) ensure that all health care providers, including HHAs and hospices, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients.

4) **Ensure appropriate development of performance-based payment for Medicare home health services.** MedPAC has recommended application of a "pay for performance" (P4P) system for home health and other Medicare provider payments. Starting in 2008, Medicare began a P4P demonstration project operating in seven states. Under that demo, home health agencies qualify for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in reducing overall health care spending. Congress should monitor the progress of the ongoing P4P demonstration and use the findings to guide its consideration of a full-fledged value-based payment system for Medicare home health services.

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United States House of Representatives
Committee on Energy and Commerce, Subcommittee on Health
"Strengthening Medicare for Seniors: Understanding
The Challenges of Traditional Medicare's Benefit Design"
Thursday, April 11, 2013

Mr. Chairman and Members of the Subcommittee:

I am Max Richtman, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare (NCPSSM), and I appreciate the opportunity to submit this statement for the record. With millions of members and supporters across America, the National Committee is a grassroots advocacy and education organization devoted to preserving and promoting Social Security, Medicare and Medicaid. As you know, these programs are the foundation of financial and health security for older Americans. Today, I will address our concerns about proposals to restructure Medicare's benefits that would reduce federal spending by requiring beneficiaries to pay more.

Medicare beneficiaries have modest incomes and they cannot afford higher out-of-pocket costs for the health care services they need to treat their multiple chronic conditions and cognitive/mental impairments. People from communities of color have a higher risk than whites for certain chronic conditions such as diabetes. According to the Kaiser Family Foundation, over half of Medicare beneficiaries had incomes of $22,500 or less in 2012, lower than 200 percent of the federal poverty level, and their savings are very modest. Two-thirds of African American and Hispanic beneficiaries have incomes below this amount, and they make up a large share of beneficiaries who have incomes below 100 percent of the federal poverty level. On average, Medicare households spend 15 percent of their income on health care, which is three times more than non-Medicare households spend.

Medicare could be improved for beneficiaries by simplifying its cost-sharing requirements and adding a catastrophic cap. The current Medicare fee-for-service (FFS) program is complicated because there are different deductibles, copayments, and coinsurance for different types of services. In many cases the cost-sharing is quite high, and Medicare does not have a limit – a so-called "catastrophic cap" – on annual out-of-pocket spending, which is found in most large employer plans. Many Medicare beneficiaries are paying premiums for Medigap insurance or retiree health benefits to cover Medicare deductibles, coinsurance and copayments. They are also paying a large share of their incomes for health care services not covered by Medicare such as vision, dental and eye care as well as long-term care.

However, recent proposals to reform Medicare's benefit design -- by combining the Part A and Part B deductible, expanding coinsurance for services such as home health care, limiting Medigap coverage or making it more costly, and providing a catastrophic cap on spending -- would raise costs for most beneficiaries. This is because they are intended to reduce federal spending by shifting costs to beneficiaries. Supporters of these proposals believe people will make wiser choices about using health care services, or will seek more high-value services, if

they have to pay more of the cost. We oppose these proposals because we believe additional costs could lead many seniors to forego necessary care, which could lead to more serious health conditions and higher costs down the road. Also, once a person seeks care, it is physicians and other health care providers who make the decisions about the care, tests and other services they receive.

Medicare beneficiaries are already paying a great deal for their health care, and many cannot afford to pay more. The National Committee to Preserve Social Security and Medicare believes we can strengthen Medicare's financing and improve the quality of care provided without adversely affecting beneficiaries. Specifically, we support:

- Building on the Affordable Care Act (ACA). Savings in the ACA are slowing Medicare's per capita growth and have extended the solvency of the Medicare Part A Trust Fund. The ACA also includes provisions leading to changes in the way care is delivered and paid for that improve quality and reduce costs. We support efforts to expand these improvements, including better care coordination, reforms to fee-for-service payments, and enhanced support for primary care providers.

- Requiring Part D drug rebates and allowing the federal government to negotiate prescription drug prices. The Congressional Budget Office (CBO) has estimated savings of $137 billion over 10 years if drug manufacturers were required to provide rebates for drugs used by beneficiaries who are dually eligible for Medicare and Medicaid as they were required to do before passage of the Medicare Modernization Act.

- Improving initiatives to prevent, detect and recover improper payments, including fraud, waste and abuse.

Thank you again for this opportunity to submit our views on proposals to restructure the current Medicare benefit design and to improve the Medicare program.